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ABSTRACT

This fourth volume in the series "Pathways to Practice" presents the heart of the Southern Regional Education Board's Nursing Curriculum Project, which was designed to (1) develop a set of assumptions about societal systems that impinge on the environments of nursing, (2) determine broadly the future direction of health care delivery patterns, (3) determine the types and levels of nurses essential to the delivery system projected in the assumptions, (4) determine the characteristics of practice and thereby the competencies needed by each level and type of nurse provider envisioned, and (5) broadly define the body of nursing knowledge requisite for the development of the specified competencies in the graduate of differing programs. The five chapters cover (1) Nursing at the Crossroads: The Dilemmas, (2) Nursing: A Critical Subsystem in Health Care, (3) A Role Structure for Nursing: Kinds and Levels of Practice, (4) A Taxonomy of Nursing Competencies, and (5) An Overview of the Theoretical Framework. Appendix A (Core of Nursing Knowledge) presents characteristics of entry level positions in the nursing field; appendix B is a five-page chart of expanded role programs in nursing in the Southern Region and lists institutions (by state), program title, length of program, degree received, and the director. A roster of members contributing to the project and references are also included. (HD)

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A Proposed System for Nursing

Theoretical Framework, Part 2

PATRICIA T. HAASE

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
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EDUCATION

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PATHWAYS TO PRACTICE, Vol. 4

Nursing Curriculum Project

SOUTHERN REGIONAL EDUCATION BOARD
130 Sixth Street, N.W.
Atlanta, Georgia 30313

June 1976

CE 008 526

He who through vast immensity can pierce,
See worlds on worlds compose one universe,
Observe how system into system runs,
What other planets circle other suns. . . .
 And, if each system in gradation roll
Alike essential to the amazing whole,
The least confusion but in one, not all
That system only, but the whole must fall. . . .
 All are but parts of one stupendous whole. . . .

—Alexander Pope, *Essay on Man*

This project was made possible by funds granted by the W. K. Kellogg Foundation.

Preface

With the publication of this, the fourth volume in the *Pathways to Practice* series, the Nursing Curriculum Project concludes the examination of its theoretical framework and presents the heart of its more than three years of diligent work by nursing leaders of the Southern region—the exposition of a role structure for nursing and the accompanying taxonomy of nursing competencies. Together they form a vital tool for curriculum planners in nursing education.

The thirty-six seminar members performed the yeoman task of working out the role structure and the taxonomy, but they did not have the time to discuss in depth all the basic issues and their history. The project staff filled that particular gap by researching the evolution of some of these ideas in the nursing literature, to provide an historical as well as a theoretical foundation for the seminar's work. The staff's material has been incorporated into the seminar's to form this narrative.

The groups from the seminar who worked so hard on these tasks are listed in the rosters at the end of the book. There is no adequate way to express our gratitude for their contribution. The project staff is particularly indebted to two seminar members—Dr. Sylvia E. Hart and Dr. Gwendoline R. MacDonald—for their contributions to our thinking and for their leadership at several crucial points.

Finally, of course, the project—and indeed the entire profession of nursing in the Southern region—is much indebted to the W. K. Kellogg Foundation for its financial support of this project.

Patricia T. Haase

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Introduction

The work of the Nursing Curriculum Project began in 1972 after the Southern Regional Education Board (SREB) Council on Collegiate Education for Nursing endorsed the Lysaught report (1970) and voted to seek funding for a curriculum study. The National Commission for the Study of Nursing and Nursing Education had recommended that "no less than three regional or inter-institutional committees be funded for the study and development of the nursing curriculum . . . in order to develop objectives, universals, alternatives, and sequences for nursing instruction" (p. 164). Moreover, these groups were to specify "appropriate levels of general and specialized learning for the different types of educational institutions, and . . . be particularly concerned with the articulation of programs between the two collegiate levels" (National Commission, 1970, p. 291).

SREB's Nursing Curriculum Project was funded by the W. K. Kellogg Foundation specifically to

—develop a set of assumptions about societal systems that impinge on the environments of nursing;

—determine broadly the future direction of health care delivery patterns;

—determine the types and levels of nurses essential to the delivery system projected in the assumptions;

—determine the characteristics of practice and thereby the competencies needed by each level and type of nurse provider envisioned;

—and then broadly define the body of nursing knowledge requisite for the development of the specified competencies in the graduate of differing programs.

PERSONS AND GROUPS

The Project's work was accomplished by several individuals and groups working in concert, so that there was a constant interplay of complementary ideologies and abilities.

The staff of the project might well be considered as the first group, the one that began the momentum and the one that was the constant in an evolving process. The staff made the initial decisions about methodology, about the way it would proceed to develop and define its materials and reach its goals set forth in the project proposal. Each decision, however small, tended to constrain the overall thrust and the project's direction became more clear and determined with each passing day. The director came to the project in October, 1972, with a doctoral specialization in curriculum, a master's degree in nursing, and an experiential background that consisted of not only clinical work but teaching in all types of nursing education programs. Most recently she had been director of an associate degree program. Four months later the staff was increased by the addition of a project assistant whose major responsibilities consisted of writing and/or editing the many documents and reports required in the process of assessing issues, analyzing findings, and articulating conclusions. Her qualifications for this important work included a graduate degree in English and twelve years' experience as writer and editor in a variety of fields. In June, 1973, the staff acquired as associate director a long-time SREB staff member whose more than twenty years' experience in regional education had involved her in work with nursing education in several previous projects.

The general methodology mapped out by the staff in those early months appears in Figures 1 and 2, and the interested reader is referred to them for a detailed picture of the group activities, both planned and executed.

The second group to become involved with the process was an ad hoc advisory committee composed of: Dr. Lucy H. Conant, Dean, School of Nursing, University of North Carolina at Chapel Hill; Dr. Gwendoline R. MacDonald, Dean, College of Nursing, University of South Florida; Dr. Marion I. Murphy, Dean, College of Nursing, University of Maryland; Ms. Ruth Neill Murray, Dean, College of Nursing, University of Tennessee—Memphis; and Dr. Dorothy M. Talbot, Chairman, Community Health Nursing, Tulane University. In December, 1972, this group generated additional impetus by approving the general methodology suggested by the staff and recommending persons to constitute a 36-member "working seminar" that met six times over a period of two and one-half years.

The thirty-six people, the third group to become a part of the total effort, were carefully selected to insure representation from the many occupational fields that form the entirety of nursing practice. The central notion used in selecting the seminar members was to create a continuing dialogue among teachers and practitioners, among teachers and other persons who had something vital to say about the structure of nursing education as it exists now and as it might take shape in the future. Nursing education was allotted fifteen seminar seats; three rep-

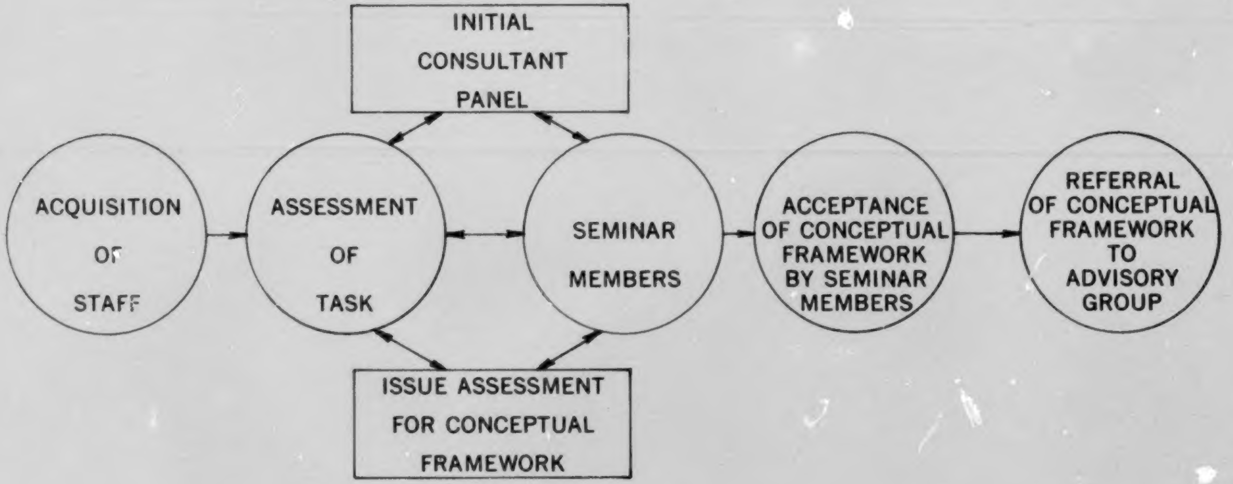
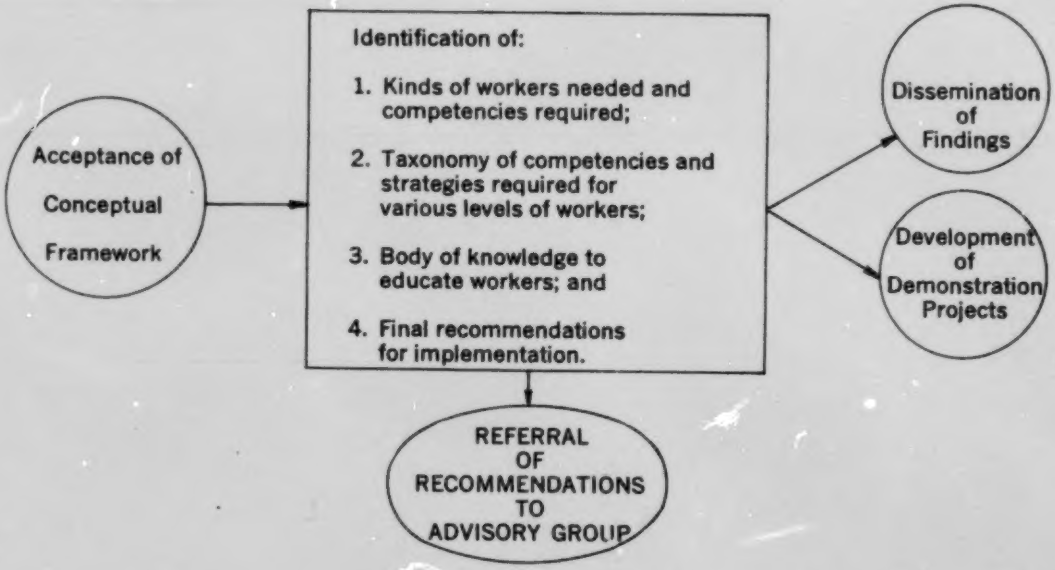

INITIAL CONSULTANT PANEL
ACQUISITION OF STAFF
ASSESSMENT OF TASK
SEMINAR MEMBERS
ACCEPTANCE OF CONCEPTUAL FRAMEWORK BY SEMINAR MEMBERS
REFERRAL OF CONCEPTUAL FRAMEWORK TO ADVISORY GROUP
ISSUE ASSESSMENT FOR CONCEPTUAL FRAMEWORK

Figure 1

PROJECT METHODOLOGY

October 15, 1972—December 21, 1973


Acceptance of
Conceptual
Framework
Dissemination of Findings
Development of Demonstration Projects
REFERRAL OF RECOMMENDATIONS TO ADVISORY GROUP

Identification of:

1. Kinds of workers needed and competencies required;
2. Taxonomy of competencies and strategies required for various levels of workers;
3. Body of knowledge to educate workers; and
4. Final recommendations for implementation.

Figure 2

PROJECT METHODOLOGY

January 1, 1974 to September 30, 1975

resentatives each were chosen from traditional programs: associate degree, diploma, baccalaureate, graduate, and continuing education. Nursing practice was also accorded fifteen seminar seats with three representatives each chosen from nursing service administration, nursing practitioner services, clinical specialists in institutional and private practice, community health services, and college and hospital vocational and in-service training programs. Other seminar members worked professionally in hospital and university administration, systems engineering, and the practice of medicine.

Despite the fact that all members were employed full-time in responsible positions, the seminar group was the core of the project, and the interplay of varying ideologies emanating from the seminar meetings became a large part of the substantive work of the project.

This group of people—the working seminar—has earned the respect and admiration of all concerned with the project, for they struggled with the usual problems of developing group cohesiveness in addition to determining the theoretical notions on which the project's assumptions and recommendations are based. Seminar members had been socialized into different systems with different and sometimes incongruent values, and it was not easy for any of them to divorce their thinking from current loyalties and vested interests and to look at the bigger picture of nursing and nursing education as it is perceived from the viewpoint of an even larger system: state, region, nation.

The seminar labored and hammered out assumptions about issues and values in the society that have a bearing on health care, new roles for women, changing concepts and practices in higher education, evolving health care delivery patterns, and finally the nature of nursing practice itself. These assumptions, known as the theoretical framework, were then converted into recommendations and plans for further action to improve nursing curricula in the South's schools of nursing so that they will match the future health care delivery patterns evolving for the nation.

In addition to the seminar group, the staff has also been assisted by another small group, a subset of the seminar. In the summer of 1973 a planning committee composed of six seminar members was formed to assist the staff in conceptualizing and formalizing future seminar sessions and planning interim activities and assignments for project members. This group made many of the difficult decisions that shaped the final aims into ones that were concrete and definitive. The members—Rachel Booth, Shirley Burd, Harriet DeChow, Jack Gregg, Sylvia Hart, Gwen MacDonald—gave unstintingly of their time and their talent and they deserve no little credit for the project's accomplishments.

The fourth group was an advisory committee that was invited to consult with the staff concerning the project's findings and recommendations and suggest changes or better strategies for accomplishing the project's goals: determining curricular universals and alternatives. The members of the advisory group brought to the staff their varying interests and values, which served to enrich and expand the entire process of change that is so intimately involved with and intended for the project's final purpose. The group consisted of: A. D. Albright, Executive Director, Council on Public Higher Education, Kentucky; Sr. Elizabeth C. Harkins, Dean, School of Nursing, University of Southern Mississippi; Dr. Calvin B. T. Lee, Chancellor, University of Maryland, Baltimore Campus; Harry B. O'Rear, Vice Chancellor for Health Affairs, Georgia Board of Regents; Thelma Shaw, Vice Chairman, West Virginia Planning Commission for Nursing; and William H. Stewart, Commissioner, Health, Social and Rehabilitation Services Administration, Louisiana.

In addition to the formal groups, the staff has sought the advice and criticism of knowledgeable consultants in all phases of the project's work. The opinions of experts have been elicited from both nursing education and nursing practice and the staff is particularly indebted to Rose Marie Chioni, Gerald Griffin, Jerome Lysaught, Marion Murphy and Irene Ramey, who read the publications in their most primitive form and made many valuable and erudite suggestions for improvements. The opinions of experts in several related areas—health planning, medicine, psychology, philosophy—have also contributed immensely to the substantive phases of the project's work.

PROCESS

The aims of the project were so broad and sweeping that the process of their attainment needed an inclusive, a comprehensive scheme. The staff began very quickly to assess the task of the project and divide it into portions of work for large groups, for small groups, and for individuals possessing a particularly needed talent and ability.

However, a comprehensive plan was essential to give structure to the amorphous quality of the work during that early period. The staff was ever mindful that the project was a curricular one and as such should be addressed to the broad concerns currently at issue in curriculum development. The project also needed to strive for congruence with contemporary practice in curricular circles, for this kind of all-encompassing concern formed one of the intersecting systems at issue in the planning process. After reviewing the literature and discussing the synthesis between the reading material and the staff's own views, several assumptions about curriculum theory and development were selected to guide the next step of the project's work.

The first assumption is a simple and yet profound one: curriculum development can be defined as a technology. Curriculum developers identify the goals of the education and engineer the means of achieving them: therefore, there is no theory of curriculum, there are only prescriptive descriptions. There are no tried and proven ways that are constant and true. The project planners had spent long hours studying Taba and Bloom and Beauchamp and had learned to identify the differences and similarities in core curricula, broad-fields curricula, process curricula, and integrated curricula, but it was concluded that these arrangements were merely different ways of categorizing and organizing teaching-learning material. Empirical foundations to establish a theory base for curriculum development had been suggested in the literature, but the ensuing investigations had, for the most part, not been done. Curriculum texts, monographs, and the many journal articles, therefore, only serve the purpose of informing a faculty on methods of procedure, assisting a faculty in arriving at consensus on curricular definitions, and keeping a faculty abreast of contemporary phraseology.

The staff further assumed that what the curricular literature does not and cannot speak to is the actual selection of the goals of an educational program, as this is more the province of philosophical ideas and current events. Descriptive methodologies and processes are helpful in determining ways of achieving desired states, but the reality of the educational program is mapped by what the faculty believes about the ends of that process. The means—or how the student can become that—are more the province and strength of teaching-learning theory and what has become a new arena of fascination—the student socialization process.

The project director had an intuitive feeling rather than a firm assumption that, since the beginning of their alliance with the field of education, nursing faculties have believed in the power of the curriculum to alleviate nursing's status and reform the health care system. In many instances nursing faculties have surpassed their mentors in education in constructing sophisticated curricula based on several complex and interrelated ideas. As a result of the nursing faculty's enticement by this notion, other faculty on the college campus are often aware that the nursing group is hard at work on yet another revision of its offerings.

The last assumption made by the project staff was the most important. If we are to accept the fact that curriculum planning, as it has been developed to date, is a technology, then it follows that the process can never be achieved in isolation—can never be an end in and of itself. The curriculum developer in nursing must work within the context of the ethos of society, current procedures in higher education, and the general directions of health care practice. Health care education, in turn, is influenced by society's demands for care and by the resulting public mandate to differing professions to provide the necessary services.

Technologies must be coupled with philosophies and theories, and the staff thoughtfully decided that the theoretical framework of the project should be built on the concept of "system"—including a philosophy of science that embraces the ideas of general systems theory—for our own small world had grown too complex for any more narrow considerations. The impact of systems theory on nursing was not new and the stretching of the mind to include the broader view of the whole was challenging and even invigorating in those early months.

The staff was then able to construct a model for curriculum development based on their assumptions about the state of curricular theory and the general notions of systems thinking. It was assumed that in curriculum development, the construction of a schematic model would be invaluable to assist the seminar group in generating alternatives, considering interactive variables, and selecting goals for curricular planning. The components of the model (Figure 3) consist of the large systems of which nursing education is a subsystem. The social ethos, the system of higher education, the totality of health care education, these larger systems surrounding nursing impinge upon it in many ways that dictate directions for future growth.

The curriculum component is at the center of the model and must be considered from the point of view of both the faculty designing a specific plan for one school and a regional group developing a plan for broader use. The project team decided that the traditional approach to developing nursing curricula would be adopted, differing only in the breadth of the base upon which a conceptual framework would be built.

The primary step in the construction of any curriculum plan is the specification of a set of assumptions known as a "theoretical framework." These assumptions, in the case of a particular institution, represent the thinking of a single faculty about nursing and nursing practice, the roles for which nurses are to be prepared, the student as learner, and the educational institution of which nursing is a part (Harms, 1969). The use of the term *theoretical framework* for a regional group refers to a set of assumptions about the future direction of nursing practice and

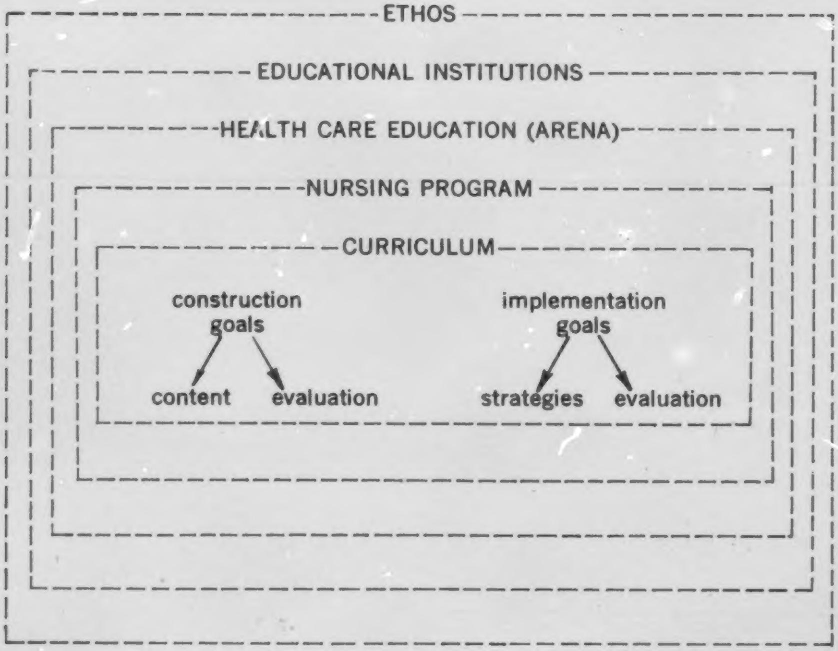

ETHOS
EDUCATIONAL INSTITUTIONS
HEALTH CARE EDUCATION (ARENA)
NURSING PROGRAM
CURRICULUM
construction
goals
content
evaluation
implementation
goals
strategies
evaluation

Figure 3

Schematic Model for Curriculum Construction

education but it is predicated upon the other systems in the model; one must bear in mind that each system is constantly changing and reciprocally interacting with the others.

The staff's use of *theoretical framework* may seem incorrect to some readers and so it may be well to point out that the use of the term does not address itself to particular theories, concepts, or integrating threads that are of prime importance to a faculty developing a single curricular pattern. Nor does our plan address itself to teaching strategies, or learning processes, or socialization patterns in the nursing curricula. Instead we have carefully examined the broad issues that determine the thrust and direction of overall educational planning, issues that are appropriate to regional efforts at curricular design, issues such as the future of higher education in this country, the future of the health care system, and most importantly, the social context that surrounds these systems and institutions in our national life.

We felt that an examination of these broad concerns would lead us to conclusions concerning the contribution of nursing to the improvement of health care and, consequently, the enhancement of our collective existence. Specifically, we hoped to come to some conclusions and predictions about the future of nursing practice upon which to base the project's recommendations.

In planning the first meeting of the seminar, the staff selected speakers who were prepared to address several levels in the model. The intention was to stimulate seminar members' consideration of these broader issues in relation to nursing education. The exchange that erupted during these opening sessions demonstrated incontestably that the social issues that impinge upon health and health service education are volatile ones. To keep momentum going and to provide a means by which seminar members could directly and actively contribute to the developing material of the project, the staff asked members to write position papers on the future of nursing and nursing education. Volume 2 of *Pathways to Practice*, entitled *To Serve the Future Hour*, is a report of that first meeting; it contains many of the speeches delivered at the sessions and excerpts from members' position papers.

Staff members then returned to their drawing boards to work out in greater detail an analysis of the four basic elements in the theoretical framework, which was now beginning to emerge in ever clearer detail. The working papers on the first three elements—feminism, higher education, and the health care system—are published in the third volume of *Pathways to Practice, A Workbook on the Environments of Nursing*, a volume that is the result, literally, of the contributions of well over a hundred persons. Actual writing was the responsibility of the staff, but as each draft—and there were many—was completed, it was submitted to the scrutiny and criticism of many consultants, including not only members of the groups named above as formally connected with the project, but many others as well, SREB staff members and "outside" consultants in many fields.

With this volume we complete the formal presentation of the project's theoretical framework by our analysis of the fourth major element—nursing itself, including the taxonomy of nursing skills. We present nursing here under the rubric of systems theory, conceiving of nursing as a critical subsystem of the larger health care and educational systems. Like the other components of the theoretical frame, this has been scrutinized by many experts and consultants. It is the product of many hands and of many hours of not only lonely thought but also lively debate. The project's staff, as always, takes full responsibility for the content, including any errors, but offers its publication fully cognizant of its indebtedness to the large number of people who have been generous with their time and their thoughts.

CHAPTER 1

Nursing at the Crossroads: The Dilemmas

THE NEED FOR SELF-RENEWAL

Nursing—as a profession and as a therapeutic process—is changing radically: It is coming of age. A change in social values is causing some alterations—the impact of the woman's movement, the increased concern for a holistic approach to persons and problems, the movement toward the prevention of disease and the promotion of health in the delivery system—and nurses have the opportunity to identify themselves with these forces and expand and advance their profession. The time is now. Some of the decisions to move forward will be forced by social circumstance but others must be deliberately chosen by nurses. Esther Lucille Brown, in her keynote address to the American Nurses's Association in San Francisco in 1974, reflected that nursing has "never had it so good" from the viewpoint of current developments that foster and contribute to the advance of nursing. In fact, she said, "Few professions . . . could have accomplished so much with the smallness of the educational leadership of 25 years ago, the acute lack of financial resources, and the expressed opposition to the closing of hospital schools by many hospital administrators, physicians, and nurses themselves." But something more is needed to promote the long-term goals of nursing's leadership and that "something" is unity on the part of all nurses to move ahead—a willingness to be open to new roles and new experiences and the will and resolve to let go of the past: to begin again.

Nursing's literature contains well-meant counsel from educators, lawyers, physicians, and sociologists who on occasion are given to the kindest of exhortations on how to improve nursing's stance among the health professions. None is better than John Millis (1970), who exhorts nurses to expand their practice into primary care. Using John Gardner's apt phrase, self-renewal, Millis says that it "best describes the type of renaissance, or rebirth, so obviously needed by persons responsible for giving or delivering health care. Self-renewal," he says, "cannot come from new laws either state or national, or from a new system or systems imposed from without. It is not a phenomenon of society. Self-renewal begins within the mind and heart of each one of us and is, therefore, deeply and uniquely personal—an expression of new aspiration, a stretching of the personality, intelligence, skills, arts, knowledge, and energy of individuals. It implies the acceptance of new confidence and new faith in oneself and in one's capabilities to achieve sought-for goals higher than any which have ever been set" (p. 63).

THE PARADOXES NURSES ARE SAID TO FACE

Unfortunately, nurses are more familiar with "apt phrases" that include the word *paradox*. Fred Davis, for example, has often been quoted about nursing's paradoxes. In the preface to his volume *The Nursing Profession: Five Sociological Essays*, he says, "Not long ago, my colleagues and I fell unwittingly into a sometimes tedious, sometimes oddly intriguing game of no known name. . . . Perhaps, it can be described as 'find a one word name for a thing.' The 'thing' under scrutiny was a mass of diverse, seemingly irreconcilable and, we feared, hopelessly unmanageable findings and impressions from our four-year study of the professional socialization of student nurses. . . . The name we settled on finally . . . was 'paradox.'

"In retrospect I believe this name was not only more appropriate to our research findings than it seemed at the time, but is equally fitting for contemporary nursing as a whole, for in bringing together the papers that make up this book, I am struck anew by the proliferation of paradoxes that characterize nursing" (p. vii).

Just exactly what paradoxes Fred Davis and his colleagues had in mind is uncertain, but his statement has been one that has teased the minds and appealed to the emotions of his nurse readers for the last ten years.

Nor are nurses finished with paradoxes. In the February 4, 1974, issue of the *Chronicle of Higher Education*, the following comment appeared: "Nursing numbers more members than any other health profession—over 2 million at work if you include students, practical nurses, aides, orderlies, and attendants. Yet nurses have had little to say about health care delivery in the United States, and nurses have often ended up dissatisfied at their inability to use their skills on the job." Quips Eileen Jacobi, executive director of ANA: "The backbone of health care has functioned in the background. . . . Nursing, that most helpful and feminine of professions, should be coming into its own, in a time of health needs and female assertiveness. Instead, it seems a lady bewildered, if not distressed by a multitude of paradoxes" (Springarn, 1974).

And it is true that nursing's performance through the years has conflicted with the expectations of outside observers. But is there a rationale that explains nursing's directions or are some changes in order for both the practice of nursing and for the education of its neophytes?

This second and last part of the presentation of the project's theoretical framework concerns the deliberations and assumptions made by the seminar about nursing and nursing practice. The deliberations began with Fred Davis's notion of "paradoxes that characterize nursing" and ended with a projection of an assertive and knowing lady whose directions are clear and precise. The staff and the seminar arrived at that projection by asking: In the ten years since the Davis statement was made, what concerns—within and without—have hampered nursing's fullest development? Or how can nurse educators, through the medium of structuring a curriculum, best express John Millis's notion of "new aspirations, intelligence, skills, arts, and knowledges" to achieve "sought-for goals higher than any which have ever been set?"

In examining some of the ideas expressed within the last fifteen years, we searched for concerns within the profession of nursing itself that have prevented our fullest development. The discussion that follows presents those central ideas.

THE STATUS AND IDENTITY OF THE NURSE

Nurses within health care—and consequently within other social systems—have traditionally been accorded low status. Some nurses feel they have less status in the hospital milieu than dietitians, social workers, physical therapists, or medical technologists. And the impact of this concern upon nursing's intelligentsia is at interface with self-renewal today. Robert Merton writing in 1962—some fourteen years ago—recognized this disquiet when he said, "The social ascent of the occupation of nursing may seem painfully slow to the practitioner of nursing, but from the perspective of the social historian, it has been remarkably rapid." Moreover, "nurses take other professions as their reference group, as their basis for judging the status accorded them and they feel relatively deprived. Accordingly, they reach out to enlarge their own competence further, to expand their accomplishments, and their collective strength and, as a by-product to raise their status a little more" (p. 72). And it is true that nursing's accomplishments have not always matched its aspirations.

Part of that failure has been nursing's inability to convey to social institutions and then to the public its aspirations—or perspectives for the future—and most of all its past record of achievement. Many of the aspersions that are cast its way come from the general misunderstanding of the word *nurse*. The public usually uses it to mean females dressed in white and found in hospitals. But the occupation of nursing uses it quite differently, if not more cogently. Many nurses caught in the "differentiation of workers" dilemma have for the most part reneged: "A nurse is a nurse is a nurse." Other health care workers continue to act out, if not speak out, their traditional "handmaiden" philosophies. But all those transgressions must be forgiven because nurses are also uncertain of the meaning of the word *nurse:* Does it mean the nursing assistant, the registered nurse, or the registered nurse with a baccalaureate or graduate degree? If the word *nurse* is "archaic and sex-linked" as Sadler, Sadler, and Bliss suggest—and as Ellen Fahy is inclined to agree (p. 99)—what is the word that will convey whatever nurses mean by that designation? Because who the nurse is—or how she is educated—determines in part the status she is accorded and, consequently, the power she may be accorded to have positive impact on health care as it exists today.

THE SCOPE OF NURSING PRACTICE

In their desire to further their interests, nurses have often retreated more than they have advanced. In 1965, the delegates to the ANA convention adopted as policy a position paper that called for professional preparation in nursing to be given at the baccalaureate level. And now nursing's leaders are saying that the initial preparation for professional practice should be given at the master's level. But movement toward that goal has been slow. In a desire to show respect one for the other, to be pleasing and deferent to the wishes of others, nurses have vacillated and hesitated to move with decisiveness. Nurses can't quite agree. Some feel that the New York Nurses' Association is moving too fast to legislate their definition of the professional practitioner, and some feel they are moving too slow. Some believe that hospital nursing is technical nursing and will be solely that until the properly educated nurse can become the role alter of the physician: one who diagnoses, prescribes, and carries out a plan of nursing care that complements the plan of medical treatment made by the physician. And others see roles for nurses and physicians in hospitals and clinics blurring and coalescing into a different kind of practice, one that is neither medicine nor nursing but a combination of both. But nursing lacks nursing consensus on the scope of practice; its right hand is not working with its left.

SPECIALIZATION: AN ARRAY OF ISSUES

In 1965 Christman projected a future staffing plan for nursing services in hospitals "organized in a pattern much like the one used by medicine" (p. 449) and staffed presumably by clinical specialists prepared in graduate programs in nursing. But since that time another kind of nurse specialist—the technician—has emerged and is actively sought by hospitals for employment. This nurse—the technical specialist—has been prepared by concerned medical staffs to fill the obvious gap in tertiary nursing care. But many graduate educators in nursing continue to pursue—and cause their students to pursue—theory and concept construction, a reaction that is beginning to show diminishing results.

Dorothy Mereness believes that today "there is considerable evidence that nurse educators are not in total agreement about the educational or experiential basis upon which graduate curricula should be developed" (p. 638). And unlike graduate programs in other professions, there is little agreement in nursing as to the necessary length of the curriculum, the admission requirements, or the essential content. Yet from graduates of such programs come the beginning instructors in generic baccalaureate programs and the clinical specialists to staff the tertiary care facilities referred to by Christman.

Moreover, some applicants to the graduate program at the University of Pennsylvania are telling Dr. Mereness that their baccalaureate education has prepared them primarily to communicate effectively with others and to understand the theoretical basis of the nursing process. The technical skills, they say, will be developed after they graduate or, as one applicant suggested, "baccalaureate graduates never need actually give patient care" (p. 638).

It is also doubtful that many graduate programs improve upon the student's clinical base. Dr. Mereness continues, "Graduate students are usually required to take two or three clinical courses during the program. Usually these [clinical] experiences involve the student as a *participant-observer* with patients or clients a few hours each week. The student focuses attention on patients who are seen in an out-patient setting and who are of special clinical interest to her. The seminar that usually accompanies this experience is generally conducted by the students, each of whom presents at least one topic during the semester . . . again, a topic chosen by the student" (p. 638; italics are ours).

And in addition to these courses, graduate programs "usually include a course in research methods, one about the profession, and one involving nursing theories during which the works of currently recognized nurse theoreticians are read and discussed" (p. 639).

Certainly such a curriculum as this does not project the clinically competent graduate desired by hospitals offering tertiary care services. Some graduate programs are producing this clinical specialist who is an expert, but not all are doing so. Part of the explanation lies in the newness of the doctoral program in nursing. Because this course of study is so underdeveloped in terms of numbers of programs and numbers of students enrolled, the tendency is to expect the graduates of master's programs to perform at the doctoral level. And for this reason, master's programs in nursing are often longer than comparable programs in other disciplines simply because the graduate faculty must attempt to prepare their neophytes for roles and responsibilities reserved for doctoral work elsewhere. The master's degree is even thought by some university administrators to represent the terminal degree in nursing. But no other discipline attempts to prepare a theoretician or an independent researcher in a master's curriculum. And no other discipline attempts to prepare master's candidates for college teaching and administration. Generalists' skills are hardly compatible with specialists' objectives.

The contradiction, the lack of expert clinicians in tertiary care when master's nursing programs are intent upon graduating them, can be explained by a lag that exists between supply and demand. It must be considered that nursing's needs for practitioners holding master's and doctor's degrees are at the moment much greater than nursing's capacities to meet them. Consequently, for several years nursing's university and health care colleagues may not appreciate how well nursing's overall efforts are reaching fruition. Unfortunately but truly, many graduates of master's programs are still needed to fulfill the traditional roles of teacher and nursing service administrator.

Moreover, the role of the nurse clinician—one that is not yet twenty years old—may be a form of tokenism for several hospitals seeking a new name for the supervisor functions, but it was originally conceived as a way of advancing nursing's practice and status. The idea of the nurse clinician first appeared in print after the meeting of the National Working Conference of Graduate Education in Psychiatric Nursing held in 1956. (The National League for Nursing published the general Consensus of that conference in 1958.)

> How different would be the situation if there were, in the psychiatric hospital, clinical specialists in psychiatric nursing—nurses who would have continuing opportunity to study mentally ill patients, to gain understanding of the newer concepts and methods of psychiatric rehabilitation, to develop nursing techniques that would be in line with these concepts! If they were on hand to take leadership in nursing care, to show what professional nursing can do for patients, other nursing personnel would respond with eagerness. . . .
>
> The demonstrated opportunities for being of real help to

> patients would attract more nurses to the field, so that eventually it might be possible to assign to each professional nurse a reasonable number of patients and aide-helpers (p. 42).

In addition, the conference concluded, this individual—the clinical specialist—could not be the person assigned to administration, supervision, or teaching.

"It must be recognized," the conference report continues, "that administrative responsibilities and responsibilities for students have first claim on these personnel. While their focus is on the care of patients, they cannot concentrate on it to the exclusion of everything else. They cannot always drop all their other obligations to follow up a promising clue to a new technique or to cooperate with members of other disciplines in exploring therapeutic by-paths. They, too, need the help which would be given by someone whose *raison d'être* is the improvement of care" (p. 43).

Five years later, in 1961, Frances Reiter continued the theme—a call for a clinical renaissance—using as her focal example the nurse practicing in the general hospital. She said,

> We are the largest single group—predominantly women—who are professionally organized and thus committed to nurturing, to helping, and to healing those whom we serve. . . . The primary purpose of this or of any other profession is the provision of care and treatment that is beneficial to the improvement of practice. . . . A sharp contrast may be drawn between the standards of nursing practice in public health nursing community programs and the collective practice in hospitals. I emphasize this point because paradoxically the conditions that influence the standards of practice in hospitals, where 85 percent of active nurses are currently employed, are controlled, for the most part, by nurses who are not presently "practitioners" but are in administrative positions, and who are, in turn, influenced by the policies of hospital administration and medical administration . . . the general staff nurse group, who give nursing care, have little control over the conditions that set the standards of excellence. The only span of control in which the practitioner can exert influence is in the direct nurse-patient setting, and this is becoming more and more limited, and constricted.
>
> The present organization of most hospital nursing service departments tends to devaluate direct nursing care and the prac-

> titioner. Bedside nursing today carries small prestige, both within and without the profession (p. 7).

As a solution to this dilemma, Frances Reiter proposed a system of clinical specialists within the general hospital. She said,

> I conceive of some "nursing teams" comprised exclusively of professional nurses, general staff nurses, clinical staff nurses, a clinical nurse associate and a nurse clinician who will serve a number of these professional nursing groups. . . . From such efforts it would be my earnest hope that we could further identify the nature of nursing problems and develop concepts of the nature of nursing practice itself as . . . a disciplined art, an eclectic science and a personal service to patients that has long-term human value and social worth. Only through professional practitioners can the professional quality of nursing practice be safe-guarded; only through extensive and meaningful practice in the clinical field can the practitioners reach their full professional stature (p. 8).

Nurses responded enthusiastically to this call for clinical renewal, and the role envisioned by the theorists began to take shape. Advanced clinical courses were developed in graduate programs and the 1960's saw nurse clinicians and nurse specialists first employed in hospitals (Cleland, 1972). But the work role of these nurses had yet to be agreed upon.

Some nine to eleven years after the initial proposal, the situation remained the same, the role was not yet institutionalized, and confusion reigned supreme. Maxine Berlinger describes the situation in 1969:

> . . . If we were to try to ascertain from a perusal of the literature a definition of clinical specialization, we would find a variety of responses. Part of the problem, as I see it, is semantic in nature. You hear of "nurse clinician", "clinical nurse specialist", "master practitioner", or "clinical expert". This tends to lead to a great deal of confusion. Another problem is a discrepancy in the definition of the role . . . in some hospitals a nurse is considered a clinical nurse specialist in one specific area, such as in a cardiovascular care unit. This nurse is usually an expert in the technical aspects of care, and in many instances, she is physician-trained. In other hospitals she is a liasion between staff and administration and may be a "glori-

> fied supervisor". Others describe her as a nurse with specialized knowledge and skill for a specific group of clinical patients, while still others state that she moves freely within an area to set standards of care. Some say her functions include a patient case load; some describe her as a model. Others say she functions as a teacher; some call her a leader of others. Some give her the freedom to move in and out of an area and some insist that she maintain her functioning in a confined unit (p 17).

The troublesome problem in 1976 is one predicted by Luther Christman eleven years ago. He said then,

> . . . It may not be surprising to find some who advocate that the "specialist" need not advance through an academic pattern of degrees but that she can become a specialist by means of experience and self-learning. Perhaps what is emerging are two different types of specialists. If this is true and desirable, then the profession of nursing and others will need to be cognizant of the worth and value of both and safeguard their roles as members of the health team (p. 447).

In 1976, there are indeed two types of clinical specialists existing side by side: One type is educated in graduate programs in nursing (the generalist) and the other is educated in ad hoc programs usually sponsored by medicine (the specialist). The specialist prepared by either medicine or nursing usually finds more acceptance in hospitals than the clinical generalists prepared by graduate programs in nursing. The reasons for this are complex, but most nurses agree that, as the clinical specialist is nursing's chance to provide a role alter for the physician, a role that nursing has long awaited, nursing and not medicine should be the focal point for the clinical specialist's education. The central problem seems to be that nurse educators must condense too much knowledge into the contemporary master's curriculum. The clinical specialist must be a practitioner prepared to know more about less—an expert in one phase of clinical practice.

As Berlinger suggests, the "advancement of knowledgeable nursing practice is of great importance, as is defining the autonomy of the nurse practitioner. This is what the clinical nursing specialist must accomplish" (p. 16). And it is certain that the quality of care can be no better than the competencies of the persons actually giving direct care to patients.

PRIMARY CARE: NEW ROLES FOR NURSES

New opportunities for nurses are being created. In fact, it appears to many observers that nursing stands on the threshold of a rapidly advancing professional status particularly with respect to primary care services. The public has wanted more primary health services since the demise of the family doctor, but medicine has continued to advocate specialized services and the use of sophisticated technology in client diagnosis and treatment. As a result, no one is presently filling the gap between the care given to the acutely ill individual and the care desired by masses of persons whose goal is high-level wellness. The concentration of medicine on dramatic technological interventions in acute illnesses has given little attention to preventive and rehabilitative services. And specialized practice in medicine has largely ignored the care of the mostly well, the chronically ill, the mentally ill, the retarded, and the aged. Nursing now has the opportunity to provide many of these health care services and fill this gap.

It began in the sixties. Stokes, one of many, observed that,

> . . . one of the serious problems confronting the medical team, for which both medicine and nursing share responsibility, is the "professional gap" which has developed and which is widening between nursing and medicine. Medicine is still saddled with the outmoded concept that a doctor shoud be trained as an independent professional capable of dealing effectively with any diagnostic and therapeutic problem with which he is presented. We are well aware of the need for a superbly trained, broadly based physician capable of dealing with the health information explosion which has tended to make the doctor seek refuge in a narrow, technical expertise. However, we have not been realistic in considering the implication of the fact that head colds are more common than Addison's disease, and that it does not take 12 years of college, medical school, and post graduate training to teach a physician how to prescribe relief for a runny nose.
>
> Nursing is also responsible for the widening gap. Although the trend away from hospital based diploma programs toward academically based baccalaureate programs is a step in the right direction, there has been a parallel tendency to emphasize pedagogy and administration as the only paths for nursing advancement. Unfortunately, to my mind, advanced clinical training for those nurses interested in direct patient care has not kept pace with the need (p. 1442).

One avenue for increasing clinical competencies was the nurse practitioner role, and pediatricians were among the first to advocate advanced clinical training for nurses. Dorothy Mereness (1970) reports a study by pediatricians that finds, "They spend 50 percent of their professional time examining well babies and counseling mothers about the care and feeding of well children. They reasoned that they could free themselves to attack the more interesting and challenging problems of ill children if they could find another group who could take over the important but less professionally demanding aspect of their practice—dealing with the normal child" (p. 31). Nurses were the selected group.

The handing down of tasks from medicine to nursing was not new to either discipline, but the unfortunate aspect of this process was the doctor's wish to call this new role—at the interface between the disciplines—the physician's assistant. As reported by Mereness, nurses responded in the manner expected:

> —We object to the use of the title "physician's assistant"—as such a title is reminiscent of a period when the nurse was literally the assistant who had no independent functions and could perform only such duties as were delegated by the physician" (p. 32).
>
> —Of course we want doctors to have help . . . [but] . . . our responsibility is to deal with the problems of nursing and not help medicine solve its problems. We reject the idea of physician's assistant because it will deplete the ranks of nursing (p. 31).
>
> —Nurses believe that the well-prepared public health nurse traditionally provides many of the services which are being requested (p. 31).

But the moderate opinion—the one with which most nurses could agree—was summarized by Mereness. She said, "It seems obvious that well-prepared nurse practitioners from high-level masters' programs are prepared to provide a more sophisticated level of service than is being visualized for the physician's assistant. Unfortunately, these highly capable nurses are in such short supply that many physicians have never heard of such a worker . . . in other words, many physicians still are unaware of the knowledge and skills today's nurses are able to bring to their patients." Moreover, "the traditional use that has been made of the abilities of the professionally prepared nurse has been short-sighted and wasteful of talent and manpower" (p. 32).

But, she continues, "It is clear that the professional nurse must accept greater and more significant responsibilities in the future if the health needs of the people are to be met. The . . . [nurse practitioner role] . . . could be one opportunity for nurses to accept responsibilities beyond those usually expected of the well-prepared nurse. If members of organized nursing continue to view with alarm this development and others that are bound to come, they may be relegated to the role of observer and lose an opportunity to shape the destiny of the profession which they have served so steadfastly" (p. 33).

Sadler asked in 1973, "At a time when the demand for personal health services is increasing, when some form of national health insurance is near, when few physicians are trained for general practice, and when half of the nation's nurses have left clinical work, who will provide the bulk of primary health care in the United States?" (p. 7) And the debate continues.

When Loretta Ford recently testified before the House Committee on Interstate and Foreign Commerce's health subcommittee, she verified that many persons were alarmed in the sixties about the shortages of health care providers. But this belief has given way, she believes, to one increasingly concerned with the "quality of care provided, the educational preparation of personnel providing care, the geographical and specialty maldistribution in medicine and exorbitant costs for medical care" (p. 533).

Ford denies that the nurse practitioner role was established because there was a shortage of physicians. "Early publications," she asserts, "record the fact that the nurse practitioner evolved to provide quality health care to children in ambulatory settings, and if successful, to investigate ways to influence collegiate nursing curriculums to prepare professional nurses for this model of practice. The physician shortage of the early sixties provided the opportunity to try out new roles for nurses" (p. 533).

Moreover, as Battistella (1976) emphasizes, the push for technology in medicine "has concentrated care in high overhead hospital settings which together with the cost of increasingly complex diagnostic and treatment equipment has contributed considerably to the spiraling cost of health care through unnecessary utilization, overlap, and duplication of services. So that while there is an abundant, if not excessive, supply of highly sophisticated and costly services available for the treatment of serious and esoteric illnesses, there is a shortage of personnel and services for the treatment of more commonplace nondramatic illnesses associated with primary care and the care of the chronically ill and handicapped" (p. 14).

And it may be, as Battistella suggests, that the benefits of medical technology have also reached a point of diminishing returns. He certainly makes cogent arguments for that point of view.

> Many complex and potentially dangerous treatments may be provided unnecessarily not so much because of the incentives to overservice inherent in the fee-for-service medical practice, but because, in relation to other countries, the United States has far more trained specialists per population. The point is that specialists undergoing extensive training and socialization are driven by a technological imperative to apply their skills rather than remain idle. Activity is a measure of self worth that leads to the introduction of systematic bias in diagnostic and treatment decisions. In company with the increasing power of therapeutic and treatment modalities, this bias is a significant factor in the growing incidence of iatrogenic illness associated with contemporary medical care. . . .
>
> Biomedical technology has attained great power, but the controls over its use are essentially laissez faire, and the free enterprise system of health services so ineffectual, that medical care may be in a stage similar to that at the end of World War I when the probability of a patient benefiting from treatment was as low as 50 percent or less. Certainly the power for causing harm to the patient is far greater today than ever before, as reflected by the unknown but large number of hospital admissions caused by unanticipated harmful side effects of drugs and other treatments and by the concern, bordering on alarm, among hospitals and physicians about the growth of medical malpractice suits. Quite apart from the issue of safety, the efficacy of high technology services is more and more questionable in lieu of the increasing median age of the population and the shift from acute to chronic patterns of disease. Even highly technical services can do little to alter the course of chronic illness (pp. 14-15).

SOCIAL CHANGE AND NURSING'S FUTURE ROLE

The right to health care—a social ideal—was first defined by Congress in 1966 in the preamble to the Comprehensive Health Planning Act and since has been interpreted to mean governmental and social programs in which health care services will be considered on the basis of need rather than on the ability to pay. The taxpayer is expected to support one-half of national health care costs through such programs. But as Battistella (1976) emphasizes, the "success of medicine in the post World War II period has obscured a number of health care delivery problems which are the inevitable consequence of medicine's intensive and wide spread commitment to science and technology." And "when subjected to careful scrutiny, technologic medicine, despite its touted power, may not be able to respond appropriately to the social aims intrinsic to the concept of health care as a right" (p. 15).

And so it seems that Americans are faced with critical choices about health care resources and how to use them wisely. There is no doubt that medical specialization has weakened the traditional patient-physician bond and caused depersonalization and fragmentation in the giving of services. But to lose the good inherent in specialized services is a choice to be seriously weighed. A better option is the preparation of more generalist physicians or the delegation of many primary care services to other health care providers who work particularly with the mostly well, the chronically ill, the mentally ill, the retarded, and the aged—another worker who will provide the necessary preventive and rehabilitative services to fill the existing health care gaps. And that worker is logically the nurse.

But nursing appears to be suffering from an identity crisis, seeking a role that eludes it. Nurses are unable to divorce themselves from the values inherent in medicine, unable to devote themselves to new horizons and aspire to meet them. Nurses' aspirations for status and service will meet their accomplishments only when a better image of nursing is translated into a new identity in which they are accepted for the person they can be, giving a service, rather than for the tasks they have performed in the past.

It is difficult to tell whether the woman's movement has tended more to encourage young women to become doctors or to enter nursing and there to advance their practice base. There is no doubt that it has raised the nurse's consciousness and caused some to reconsider their plight. In 1971, Virginia Cleland spoke out about the nurse's status and woman's place in health care when she said, "Today, there is no doubt in my mind that our most fundamental problem is that we are members of a woman's occupation in a male dominated culture . . . ." She continues, "At one time I thought nursing had an advantage over other woman's occupations since in nursing women held all the positions throughout the hierarchy, unlike the occupations of teaching, social work, and library science where numbers are dominated by women but where power positions are held by men. I thought nursing had more autonomy because of this. Now I believe that was an incorrect assumption. Rather, isolation from all vestiges of power except within its own group" would seem to suggest that "dominance is most complete when it is not even recognized" (p. 1543).

No doubt the low status of the nurse in health care has been profoundly influenced by the status of women in society, but that is not a sufficient explanation. If we can return to Merton's remark in 1962 we have another answer; he said, "The modern history of nursing has recorded a continuing and marked differentiation of roles [and] it is a matter of common notoriety that the formal education of those engaged in nursing covers an extraordinary range of variability" (p.77). Our most profound concern may be now, as it has been for more than fifteen years, the differentiation of nurse workers: or put more simply, who is the nurse?

PROFESSIONALISM vs. BUREAUCRACY IN NURSING

But it is not enough to develop a new role structure including the traditional with the new, the hoped-for with the realities of our time, because nurses are also troubled with role conflict—to borrow a term from the sociologists. There are several of these dichotomous role sets; some are more troublesome than others, but most are related to each other. The first may be the most pervasive: Are nurses bureaucrats or professionals, or a little of both?

Preparation for business or educational leadership includes the study of bureaucracy from its classical state to its modern counterpart. And preparation for nursing leadership also puts emphasis upon its study, for it is one of nursing's most intractable problems, one that exists at the interface between nursing's professional education and the realities of the modern hospital. Marlene Kramer (1973) called attention to the beginning staff nurse who must resolve the dissonance this dilemma creates for her or leave the system. But the problem is even more pervasive than that faced by the novice practitioner. So many nurses are forever marked by the bureaucratic way of thinking, a method of decision-making that tends to pervade their teaching and practice: when you see this, do that; but we have always done it this way; but the policy says; but the roles are. It appears more than difficult to make cognitive leaps over bureaucratic hurdles. Bureaucratic values explain many of the paradoxes in nursing. For example, men and women are selecting nursing because they desire client contact, but many of the most talented of them are being put to other tasks. Until recently, it was a general rule that the farther the nurse was located from the patient, the higher her status in the occupational group, the higher her salary, and the higher her level of discontent with the status quo (Haase, 1976).

The movement away from the patient by better-educated nurses matches the bureaucratic model in every respect. Bureaucratic values stress the performance of tasks, strict adherence to and belief in the formal organizational hierarchy, rules and regulations, usefulness of task analysis, and reward for faithful service and longevity.

Some nurses have questioned whether professional nursing can ever be practiced in the hospital. Sister Dorothy Sheahan (1972) maintains that it is not only the bureaucratic structure that prevents good nursing practice but also the fact of who makes the "professional" decisions regarding client care. She believes that the person who makes these decisions "is the professional" and that all other workers perform at a technical level. "It is the doctor's orders, as well as his role expectations of nurses which are the principal source of control, the chief determinants, of the nurse's action and activity." She ends her article with the thought, "If power corrupts, much more so does powerlessness" (p. 444).

But Sister Dorothy Sheahan was not the first to write about the powerlessness of the nurse in the hospital. Historically Frances Reiter said it eloquently in 1961. For nurses "within the prevailing system in hospitals today, there is little incentive to practice. Until nurses are both able to and enabled to practice that quality of care that has within it a source of ever-growing self-realization, they cannot respect their services nor can they command the respect of others" (p. 10). Sister Sheahan was more direct and to the point. She said, "Professional nurses cannot practice in the hospital" (p. 442).

Nursing as an occupational group is deeply committed to the professional ideal, but nurses need to be cognizant of the changing meaning of professionalism. Abraham Flexner's criteria are no longer valid. There are no separate bodies of knowledge, no separate sets of applied activities, and no one method of payment; the organization is intervening in the client-professional relationship, in personal commitment, and in third-party payments and policies. Nursing, as an example, is an applied science that shares a body of knowledge, a therapeutic process that shares a set of applied activities, and an unlimited range of service that shares a vision of better health care for people.

The question "Are nurses professionals or bureaucrats?" might be better phrased by asking, "Is nursing preparing neophytes for a real role that exists 'out there' or for an ideal one that exists only in its hopes and dreams?" Mary I. Crawford (1964) observed some ten years ago what is still true today. She said,

> The practical nurse is probably the most fortunate of the nursing team today. Her concept of an ideal role more nearly coincides with the reality of her teaching and her actual job. Yet, neither she or the technical nurse gets much help in recognizing the unique contribution each makes to patient care. Programs preparing both types of nurses seem to emphasize their developing the same skills and understandings that the collegiate programs emphasize. Only time limitations prevent the technical and practical nurse from gaining the same background of knowledge. We might consider what we are doing, that we are building a concept of an ideal role without providing the tools to attain it. What's more these nurses have a specific and important role to play in patient care; they have a role that is going to be needed as long as there are sick people (p. 90).

And another member of this same family of problems is the role conflict of hostess or therapist. Frances Reiter said in 1961 that,

> The basic professional programs are based on social needs and not on occupational ones. They do not prepare the student to meet the realities of the hospital situation in the set model of the crystallized hospital culture in which there is almost no opportunity to practice or to develop a high degree of clinical competence. In no other profession that I know of—medicine, social work and even teaching and the ministry—is there so great an attempt to expend the energies of professional personnel on tasks unrelated to their practice and thus dilute the professional services at the cost of the quality of the practice itself. This problem has become crucial. There are at least three alternatives: one, to give up the professional objectives, based on social need, for those based on occupational needs, which would mean that nursing would cease to be a professional service; two, to create new patterns of hospital nursing care and staffing that would be designed for the improvement of nursing practice through the professional use of the professional practitioner and her further development as a practitioner; and three, to pioneer in new fields of hospital service in which there appears to be the greatest social need and opportunity for creativity (p. 17).

Nor has the problem abated since that time. In discussing the work of the nurse, Davis, Kramer, and Straus (1975) have said that,

> There are two sets of tasks that have implications for the nurse's work in an in-patient setting—in addition to the activities that are called "nursing" there are hotel-like functions, and there are system maintenance functions. Historically, these have all been included in the work of the nurse, due in large measure to what Hans Mauksch refers to as "continuity of time and space". The nurse is the only person who is there around the clock—24 hours a day, 7 days a week. To her quite naturally fall the additional tasks of providing hotel-type functions and keeping the organization running. In many instances, these tasks have been so numerous and overwhelming that they have completely replaced or obliterated the work of nursing.
>
> Currently there is much discussion about these two sets of tasks. It is generally recognized that both of them interfere with nursing. Ward manager systems, unit clerks, and stewardship programs represent but a few of the attempts being made to provide the hotel functions and to maintain the organization without the nurse having to do these tasks. The extent to which they are effective is still to be determined (pp. 1-2).

CARING vs. CURING: THE BASIC ISSUE

And last but not least, are nurses healers or handmaidens? Millis (1970) reported:

> I once overheard a nurse ask "Is the physician the boss, or the nurse, or are they equals?" The answer is sometimes one, sometimes the other and, on occasion, both. Since cure is the physician's exclusive responsibility, obviously he is prime in this area. But in the universe of care, the doctor in many instances is not involved and other professions, particularly nursing, become prime. The difference lies in the fact that, in cure, the relationship of the professional to the patient is episodic; in care, it is a continuing process.
>
> The central institution in our present system for delivery of health care is the hospital. Why? A hospital is a clinical institution in which 90 percent of the health care is delivered to bedded patients and 10 percent to vertical or ambulatory patients. It was designed specifically to care. But our vision has

> been so narrow that we have built the greater part of our delivery system around this tiny part of the health service universe, and expect it to carry out all service functions even to setting up health stations in ghetto areas. This is to wear the blinders of faulty conceptualizations—faulty semantics—equating the work of "cure" with "care" (p. 64).

Cure means to heal, to make well, to restore to health, and in common usage it has come to signify complete resolution.

> A focus on the therapeutic process [on the other hand] directs attention to the person in need of health service. One finds satisfactions not only in the resolution of the problem but in work with the person and in the study of the behavioral and physical phenomena associated with his problem, with the abstraction of a theoretical formulation from an examination of clinical data and theory, and with the development of interventions to effect a change in the conditions or promote an adjustment to the situation. This work can contribute to the resolution of an illness or a health problem but may not result in care: it will lead to knowing the person who is struggling with the condition and thus to one of the richest satisfactions.
>
> Minimal success in the patient's mastery of the situation or his process in handling the main problem can be rewarding (Gregg, 1967, p. 21).

Care is not akin to cure, said Frances Reiter in 1957. Care is more related to "pathos" in that feelings are experienced and responded to by extending oneself to another. Care is expressed in attending to another, being with him, assisting or protecting him, giving heed to his responses, guarding him from danger that might befall him, providing for his needs and wants with compassion as opposed to sufferance and tolerance, with tenderness and consideration as opposed to a sense of duty, with respect and concern as opposed to indifference.

This role conflict actually illuminates how nursing differs from medicine. And it is enlightening to examine the philosophy of Loeb Center for its answer, one that today's nurses could readily subscribe to (Bowar-Ferres, 1975). "Organizationally, Loeb offers the registered nurse a setting in which she can develop her role unencumbered by the things that are not nursing. Nursing is developing fully and demonstrating its value and difference from medicine, yet showing how nursing and medicine need to and can work interdependently. *Loeb is run* *by nurses;* its service is primarily nursing, and only nurses can determine nursing" (p. 810).

The philosophy of practice envisions three interrelated components, each defining a specific client need.

> [First] is the care component. Nursing traditionally provides care and comfort for the physical well-being of those who require help in meeting their own needs—the sick, the injured, the very young, and the very old. Caring and comforting, the intimate bodily caring of bathing, feeding, toileting, dressing, and moving—all closely related to nurturing—is the area of nursing that no other discipline shares. A physician, social worker, or pharmacist has very little to offer a patient in this area aside from giving us some of the general principles which we have adopted. The nurse has historically provided care to infants and taught the mother how to continue that care. Caring of patients directly, the laying on of hands . . . , is the key that opens the door so that the nurse then may use other skills to help these patients.
>
> The second component of nursing, cure, is obviously shared with the physician, pharmacists, dietitians, and many others. Curing may be seen as healing or arresting the disease process, or it may be extended to include prevention of disease as well. Nurses often become more involved in prevention than physicians, since their goal is more directed toward helping people cope with the stresses and stressors around and within them—often preventing crisis and irreversible damage. Nursing's role with the care component is not to help the physician, but to help the patient make use of the physician's help in whatever way that patient can most successfully do so.
>
> The third component, the core, is the aspect relating to the person of the patient, the self. Everyone [has access] to the patient. But the nurse has the unique advantage of being in a position to have more access . . . if she uses it (p. 810).

CHAPTER 2

Nursing: A Critical Subsystem in Health Care

DEFINING NURSING

When the preliminary report of the project's findings and recommendations were presented to the SREB Nursing Council in October 1974, one member rose during the discussion and announced, "They haven't done it; they haven't defined nursing!" The remark struck a sympathetic chord in the project director's mind, causing a sudden flashback to the year 1950 and her own generic education. Ironically the 1950 message was exactly the same: "We can't do it; we can't define nursing!" In the fall of 1975, the project director attended a National League for Nursing workshop on graduate education where the participants were still at a loss "to do it—define nursing!" Obviously each group was focusing on different processes: one group addressing itself to the structure of nursing knowledge—how it should be arranged, what it should be—and the other to nursing's place under the interdisciplinary sun.

But the notion that nursing—as a profession—has yet to be defined was an empty one for most seminar members, who were in sympathy with the view expressed by Mary Tschudin in 1967. She said that whatever nursing is,

> There is ample reason to believe "it" does not change with age, or geographic setting, or medical diagnosis, any more than law, or medicine, or teaching change with such variables. Certain activities may change; certain modes or methods of practice may change; the problems encountered in practice may differ in degree or even in kind; but the central purpose of the profession and the reason for its being does not change with the shifts in the location of patients, or the age group involved, or the category of disease [or state of health, as Tschudin might say today]. It is on the basis of the existence of a central purpose in being that professions are identified and differentiated and by virtue of which they endure over time (p. 3).

DEFINITION DEVELOPMENT: THE "UNIQUE FUNCTION" PERIOD

In 1964 Virginia Henderson suggested a definition of nursing that became the cornerstone of many beginning nursing courses. It is as familiar to some of us as the Florence Nightingale pledge, and it begins with the suggestion that the unique function of the nurse is to "assist the individual, sick or well, in the performance of those activities contributing to health or recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible" (p. 62). But then—from the viewpoint necessary to the 1980's—the definition slips into one describing a dependent nursing role in secondary care. For, as Henderson tells us, the nurse was to carry out or assist the client to carry out the plan of care "prescribed for him by the physician." The unique function of the nurse was to "complement the patient" by supplying what he needed (strength, will, knowledge) to perform his daily activities (p. 62).

This definition is not only a classic to nursing history but socially adaptable to the nursing role and responsibilities in 1964. It gives us pause to think that by 1976 these same ideals have sometimes come to be labeled in a self-accusatory sense as "mother surrogate" or "physician's handmaiden". Neighbor, writing in 1970, described the traditional qualifications for the nurse of the past to be "unquestioned obedience to the physician and other persons in authority positions" and "unlimited deference to the apparent well-being" of the client. Nursing in the traditional sense, Neighbor observes, is a combination of dependent technical competencies and the humility "to conceive one's own sense of well-being in an almost direct relation to that of the patient: to perform the mother role" (p. 35).

But the search for a unique function continued into the mid-1960's. Goodsen (1966), speaking to the task of curriculum construction for a professional school, stated that "finding the mission and goals of the profession is a crucial undertaking for the faculty . . . [for] . . . without charity of mission, there cannot be a meaningful program of education. The mission represents the broad purposes and responsibilities which members of the profession subscribe to and which leaders of society . . . assign to the profession. Although the missions of many professions may overlap, each profession must have a unique service" (p. 799). But the unique function of the nurse still eluded description, most probably because it was narrow in scope.

THE HOLISTIC VIEW

Seeking a unique function was still in the ascendancy in the late 1960's but the focus had been slightly altered. In 1967 nursing moved from the more isolated position of defining itself in terms of a unique role to one of perceiving itself as sharing roles with other disciplines. Moreover, the astute observer will notice the impact of a different philosophy of science upon the writers of definitions such as Dorothy Titt (1967), who said that nursing was only "one of several professions that have [the] overall goal" of providing the health care services mandated by the public. Nursing contributes a "sub-goal" to the achievement of better health care in a circumscribed area "in which we are *accorded autonomy* as a consequence of our special competence" (p. 13; italics are ours).

In 1971, the move toward autonomy was made nationally visible in a bill sponsored by the New York State Nurses' Association—and subsequently passed into law—that defined the practice of professional nursing as "diagnosing and treating human responses to actual or potential health problems through such services as case finding, health teaching, health counseling, and the provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist" (News: June 1971). The intention of this amendment to the New York Practice Act was to specify the elements of the nursing process clearly and to clarify the independence of the professional nursing function. The framers of the amendment defined the diagnostic process as an intellectual one that is central to the practice of several professions: one that varies with the focus of these professions' responsibilities to and mandate from the public.

Another liberating view was also proposed in 1971 by Nathan Hershey, who became controversial in nursing circles when he said, "I think that the most profound changes in nursing practice will come from the increasing realization that nursing is not a single profession or discipline, but represents a wide—or even unlimited—range of potential service" (p. 1410). Mr. Hershey was obviously referring to nursing's growth during the preceding decade and its inability to come to grips with the problems presented by: (1) the need to differentiate and institutionalize into practice-milieus the varying levels of nurse-providers, (2) the proliferation of new roles and positions for nurses in hospitals and other settings, and (3) the increasing possibility of narrow specialization in nursing practice.

Uniqueness of role was fast becoming a relic of the past. In 1975 the Nursing Curriculum project members defined nursing in accordance with Mr. Hershey's concept of nursing as a profession of "unlimited potential" and not a solitary endeavor but a "wide range of potential service." The project's assumptions about the future of health care led to the conclusion that the years ahead portend little uniqueness in role for many health care practitioners—practicing beyond the technical level—certainly not in primary care settings, and, if coronary care units and other intensive care units are a harbinger of the future, then not in acute care settings either. The only unique pattern that still holds is that nursing does differ from other health care disciplines in the average amount of time spent with the client during an illness episode and in the exact kinds of behaviors employed in the illness setting to assist the client to return to a state of health. The project director has always been intrigued because she recognizes the truth in Mary Reres's notion that "expert nursing care is milieu therapy in illness settings" (personal communication, 1975).

In 1976 nursing can no longer be portrayed by simple declaratory statements—any more than medicine, education, or law can be described in this way. Indeed, the complexity of the modern world invites the construction of paradigms that convey in linear fashion many realms of meaning. No, we haven't done it, we haven't defined nursing in catchy phrases or erudite clauses, but we have attempted to define avenues of potential growth for nursing.

THE PROJECT'S DEFINITION OF NURSING

For the purists, nursing was defined as one of the major sectors of the health care system; seen from the point of view of systems theory, nursing is a critical subsystem, a part of an interdisciplinary effort to promote and maintain health, prevent disease and disability, and to care for, cure, and rehabilitate the sick.

The aim of nursing is to assist individuals, groups, or even larger systems to achieve self-determined health goals, reach a state of adaptation with their unique environment, maintain or improve their pattern of functioning, and integrate the related facets of their health-illness state into a unity that has meaning for the present and direction for the future.

This goal is operationalized by assisting clients to cope with varying degrees of psychosocial and biophysical disequilibrium through continuing services based on the client's desire for them.

DEFINITION OF THE WORD "NURSE"

Deciding who practices nursing was the most difficult problem confronting the seminar participants. In fact, the definition of the word *nurse* was of greater concern to us than defining the range of nursing services or the body of nursing knowledge. The seminar assumed for purposes of the curriculum study that the nurse was that person who gives nursing services to clients, regardless of environmental setting or the nurse's educational preparation. We applauded Ellen Fahy (1973), who said, "Although I am inclined to agree with Sadler, Sadler and Bliss on the use of the word 'nurse' as being archaic and sex-linked, when one is dealing in the realm of one million souls who presently have that legal designation, haste in changing it would be ill-advised" (p. 49).

Whether every individual providing nursing services should be called "nurse" was a question that was discussed in heat and discarded in relief. From the perspective of the project, therefore, nurses vary in educational preparation from on-the-job training to formal academic study at the post-doctoral level. Obviously the parameters of this definition—any individual giving nursing services—are too wide for purposes other than viewing the place of nursing in the delivery of health services. But if the word *nurse* is defined in this way it becomes logical to assume —as the seminar did—that nurses will differ by level or educational preparation and practice and by type of nursing services that each nurse provides to an individual, group, or community. It follows then that each nurse will possess sets of abilities and information that may be widely divergent from those of other nurses.

The seminar left for others to debate who should be labeled professional, technical, and vocational and who should be licensed by whom. What was vital to the participants as curriculum workers was to identify the variations in recognizable levels of practice so that the overlap in nursing roles and functions could be reduced and so that each type of student could be educationally prepared for her function in delivering nursing services. The project participants did not quibble about the existence of differences in types and levels of practice but agreed that their task was to specify these differences by nursing behaviors expected in practice for each level and type of nurse provider. The detail of these specifications for nursing behaviors was limited only by the practical constraints of the time available to the project.

THE MODEL FOR NURSING PRACTICE

The project participants examined closely the applicability of the Lysaught model of the variables in nursing practice (1970, p. 65) to their own goals and assumptions. A three-dimensional model does portray the concept of an unlimited range of service requiring different levels and types of nurse providers. But to adapt the Lysaught model to their own thinking, project members changed the labels of nursing behaviors (the tasks of assessment, intervention, instruction) to broader concepts—*functional, human,* and *conceptual competencies*—and devised somewhat more elaborate conceptions of the two other continuums, *setting* and *patient condition.* Thus, the project's own model (see figure 4) represents a synergistic process that captures well the complex nature of the project's conceptualization of nursing practice.

Other words could have been used to label the nursing behaviors identified by the project members: They might have been called "technical," "affective," and "cognitive," for example. But the words *human, conceptual,* and *functional* were chosen because they have the broadest meaning possible; they have not previously been associated with psychological and educational research, and they are not emotionally charged with other meanings.

Functional behaviors may be thought of as those—whether unique to the nurse or shared with other disciplines—which insure physical comfort for the client and implement diagnostic, preventive, and treatment protocols. Functional competencies are an integral part of any professional practice.

Human competencies include that large portion of nursing practice that is based on communication and interpersonal processes.

Conceptual behaviors include the recognition of cues, the identification of needs and resources, and the analysis and synthesis of knowledge into clinical decisions and evaluative processes.

Functional, human, and conceptual abilities and behaviors usually are included jointly in the nursing process: a synergistic action. And the more complex the behaviors required, the more highly developed and interrelated the competencies needed by the nurse. In other words, it was assumed that the nursing—the actual thinking, caring, and doing—combines different sets of functional, human, and conceptual competencies. In fact, these sets of abilities are difficult—if not impossible—to separate from each other even for purposes of study, but some division was necessary to tease out the exact behaviors required for varying levels of nurse providers.

The seminar members' notion of settings for practice have been described in the project's publications as primary, secondary, and tertiary. But suffice it to say that environmental settings for nurse practice were central to determining not only levels and types of practice needed, but also characteristics of practice demanded by the environmental settings.

For purposes of the model, the nature of the client was defined in such a way as to include: his place on the health-illness continuum (varying from high-level wellness to critical illness); the nature of the health-illness problem he presents (varying from a state of health to a life-threatening acute illness episode); his age (varying from the beginning of life to actual death); his socioeconomic status; his cultural identification; his value system; his assumptions and expectations for self and others; his personality structure; his knowledge base; and his ways of perceiving and knowing (to mention but a few). The curriculum worker might perceive each of the above to vary on a continuum or might perceive each to be a discrete body of knowledge about man.

The seminar members wished to include an additional dimension concerning the nature of control in the decision-making process. By this term they meant the freedom of the nurse to make clinical decisions without referral to others or to policy. It may be that this factor is subsumed under setting, but in any event, the seminar participants felt it important enough for special consideration. However, as the addition of a fourth dimension proved to be impossible to represent graphically and maintain the concept of intersecting axes, the decision was made to present the concept only in the text.

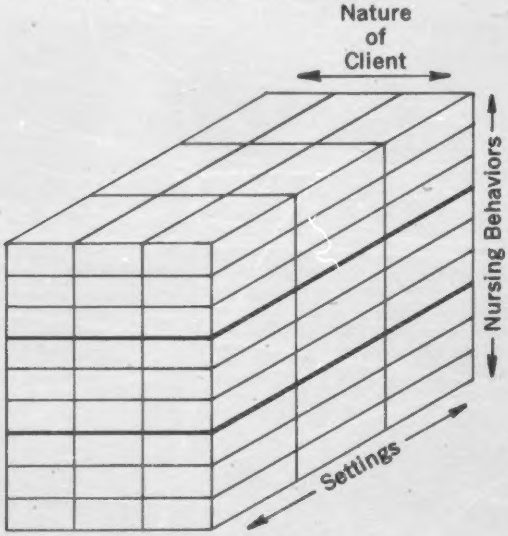


Figure 4. Major Variables Determining the Levels and Types of Nursing Practice

CHAPTER 3

A Role Structure for Nursing: Kinds and Levels of Practice

THE NEED FOR A ROLE STRUCTURE

Role definition has been the most knotty problem to have troubled the advancement of nursing for several decades: Is it one role or many? An accepted role structure appears not to exist.

Frances Reiter (1961) suggested one some fourteen years ago but "it never caught on." She said,

> The general staff nurse on the basis of competence in practice could be promoted to the position of "clinical" staff nurse . . . [one who] . . . would be . . . more competent in the care of a particular group of patients. She would give evidence of developing clinical judgment and technical competence in the care of patients with neurological, cardiovascular, or cancerous diseases or in the rehabilitation of . . . [these] . . . patients. . . . The next staff position . . . that might be created is . . . "clinical nurse associate". In this position the nurse would not be an "assistant doctor", but would function as a clinical nursing associate of the physician or group of physicians in a clinical specialty. She would make rounds with him, see his . . . patients, plan for medical-nursing management of those patients, with him, and personally follow the care of these patients. As a competent practitioner she would design, plan, and direct the nursing care given by others, and participate in regularly scheduled clinical conferences and in planning for continuity of care. Beyond this, I conceive another position within the hospital medical center, namely, that of a "nurse clinician". This nurse would be a clinical nurse specialist because of her advanced clinical knowledge and expertness in clinical practice. I see her as a nurse practitioner who consistently demonstrates a high degree of clinical judgment and an advanced level of competence in the performance of nursing care in a clinical area of specialization, such as pediatrics, geriatrics, cardiac disease, chronic diseases, psychiatry, neurology or special medical-surgical nursing. For the nurse to have attained this stage of professional maturity—that is, clinical nurse specialist—she

> will have had extensive and intensive clinical practice made meaningful by concurrent study of the nature of these nursing problems (pp. 7-8).

But this "role structure," of historical interest to academicians and clinicians in tertiary care, was done some years before the advent of new and expanded roles for nurses. The traditional illness-oriented role described by Reiter is changing in primary care settings to one that shares functions with other health care providers. In fact, some observers feel that the nurse will become the gate-keeper to the entire public sector of health care within the next decade. Current estimates indicate 15 percent or less of the actual health care problems presented for solution will require the utilization of secondary and tertiary care facilities; 85 percent of the care needed will require health education, physical and emotional assessment, counseling, and management of regimens for chronic conditions and disease prevention.

Moreover, practice rather than education has determined the direction of this development. Valencia Prock in 1970 observed that "Role innovation in nursing either in public health or in institutional nursing has not come from faculties in schools of nursing . . . [but instead] . . . the impetus for creating and using these new roles in nursing has come from the fields of practice. . . . Currently, almost all programs for expanded new roles for nurses exist outside the main stream of nursing education. They are special enterprises which are sponsored by group practices, service projects, medical colleges, and schools of public health" (p. 12).

Nurses practicing in the expanded role in primary care will eventually change the meaning of nursing as we know it today.

In 1975, Ruth Freeman defined community health nursing as "an area of human services directed toward developing and enhancing the health capabilities of people, either singly as individuals or families, or collectively as groups or communities." She continues, "The goal is to enable people to cope with discontinuities in and threats to health in such a way as to maximize their potential for high level wellness and to establish reciprocally supportive relationships between people and their environment" (p. 1).

Community health nursing, Dr. Freeman says, has an ongoing responsibility to: the population-in-environment unit; individuals and families whose well-being in the aggregate is community health; continuing rather than episodic events and conditions; situations in which the outcomes of care depend predominantly upon the decisional and behavioral responses of the people involved—rather than the highly specialized personnel and "hardware" of the large hospital or medical center.

In response to this definition and in view of the changing expectations of the nurse by the community, it is reasonable to believe that the nurse working in that aspect of community health nursing known as home care will expand her services to include clinical assessment, clinical decision-making, and treatment of chronic diseases. Moreover such care, and also cure, will be demanded in the home for non-ambulatory clients due to the rising cost of in-patient services and the desire of the client to return to his home as soon as practical after hospitalization or to remain in his home in lieu of hospitalization. Nurses will see clients in the home not only to assess their health-illness state and monitor and manage the chronic disease, if any, but to instruct the client and his family on their health care concerns, to counsel the client and his family supportively and therapeutically, to find cases and refer clients to the appropriate health agencies and, last but not least, to become the client's advocate in the community and state system of health services.

The nursing clinic is also coming into its own. With respect to this development it is interesting to examine the analogy between progressive care and ambulatory care as proposed by Dr. Charles E. Lewis and Barbara A. Resnik. They suggested that the concept of progressive care had been accepted and applied in hospitals and that logically the same concept could be applied to ambulatory patient care. "Three levels of . . . care might be proposed," Esther Lucille Brown quoted them as saying, "the acute or intensive level that requires the technical expertness of the physician; an intermediate level that requires monitoring of the status of the disease process, surveillance of therapeutic activities, and attention to the psychological and social aspects of care; and self-care, in which health education, health promotion, and prevention of disease are the goals. Although physicians should be capable of providing all three levels of ambulatory care, it is unrealistic to assume that there will be enough doctors in the foreseeable future to permit any such complete service" (Brown, 1971, pp. 245–246). And so nurses had another opportunity to be of service and to advance their standing among health care disciplines.

Nursing clinics are now flourishing, many sponsored by schools of nursing in the South having both graduate and undergraduate programs. And nurses are moving out into solo practice or group practice with other nurses or physicians, doing relatively well offering a brand-new health care service. Many are working part-time in solo practice devoting their efforts to problems that are strictly nursing and others are working collaboratively with physicians to monitor disease processes that fall into the realm of medicine. But wherever these nurses practice in an expanded role, their functions are likely to "spill over the border of traditional nursing, counseling, and caring functions and into clinical decision-making, medical diagnosis, and treatment" (Sadler, 1973, p. 11).

Esther Lucille Brown records Dr. Lewis's and Ms. Resnik's thoughts about the institutionalization of this new nursing role into health care practice. They say, "Although the patients in the outpatient department shortly came to accept the nurse who performed functions formerly done by physicians and although the nurse clinic was able to demonstrate many assets," there are "obstacles that hinder the spread of such clinics. The state licensing laws presently do not permit a functional definition of the medical-legal responsibilities of those involved in caretaking, and hence, would probably need to be revised. What is more important, physicians are not accustomed to sharing responsibilities for care and the resultant satisfactions, let alone the economic rewards. Some nursing educators, moreover, insist upon the identification of a body of nursing theory, science, and functions separate from medicine, thus hindering the achievement of inter-professional goals" (1971, p. 247).

The time is also right for the creation of nursing units and hospitals to provide services for that part of the population for which nurses have already been prepared in our schools of nursing, that part of the ill population which medicine eschews: the chronically ill, the aged, the mentally ill, the retarded. Either because nursing lacks enough educationally prepared nurses or because we cannot attract a sufficient number of them from the fascination of dramatic technological illness intervention, we have established few nursing units or extended care facilities like Loeb Center, where "the core of the program is its nursing service; the nurse is the chief therapeutic agent and the final 'effector' in providing interrelated patient care. Units where other members of the health professions serve as resource persons and consultants, who furnish direct service to patients requiring it . . . with the aim of hastening the healing process, decreasing complications and recurrences . . . promoting health and preventing new illnesses" (Brown, 1970, p. 159).

Nurse educators have faced that age-old dilemma commonly referred to as being "between the devil and the deep blue sea." Should they prepare graduates for one level of practice or two or three or more? Have we addressed ourselves more to our aspirations—our dreams for the future—than to the realities of the work milieu? Have we asked ourselves the right questions, such as: (1) What is expected of the workers in the employment milieu? (2) What is the optimal performance? (3) How can the milieu be matched to the educational program that prepares the worker so that the novice nurse experiences maximal job satisfaction and the organization maximal job performance? Educators say hospitals are dictating nursing roles, but the question goes much deeper: In perpetuating our ideals, are we addressing the reality of changing health care practices?

DIFFERENTIATING WORKERS: A PROPOSED ROLE STRUCTURE

The seminar members addressed themselves to the classification of roles dilemma by asking simply: Is there a common base of nursing knowledge that can be identified in terms of common competencies expected from graduates of different preparatory programs? Do all nurses possess a common base of knowledge upon which to predicate their practice? What does the staff nurse working in a secondary care institution have in common with the coronary care nurse, community health nurse, nurse practitioner, and nurse midwife?

To answer these questions—after the initial two meetings of the seminar—each project participant was assigned to one of four task groups. The purpose of each group was different, but together they were asked to define the recognizable and projected levels and types of nurse providers needed by the future health care delivery system and to match these with the broad nursing competencies that would be required for each provider identified.

The schema that the task group on projected roles devised is illustrated in Figure 5. "Nurse educators assigned to the task group were in the minority," Dr. Gwendoline MacDonald notes in her chairman's report, "so it can be safely concluded that the schema effected was primarily influenced by the beliefs of those active in nursing practice" (such as primary care nursing, vocational nursing, community nursing, institutional nursing). But the interpretation of the schema will require an exploration of several of the *assumptions* made by project members in relation to nursing practice.

ASSUMPTIONS ABOUT NURSING ROLES

1. The first assumption appears simple and yet it is the cornerstone of the rest. And that is: The public mandate to nursing is and will continue to be the direct care of clients.

2. This assumption makes the second a fixed one. It has been said many times, but we choose to cite Hildegarde Peplau (1965), who said, "Clinical practice is the center of nursing. The primary commitment to society of the profession of nursing is the practice of nursing; all other

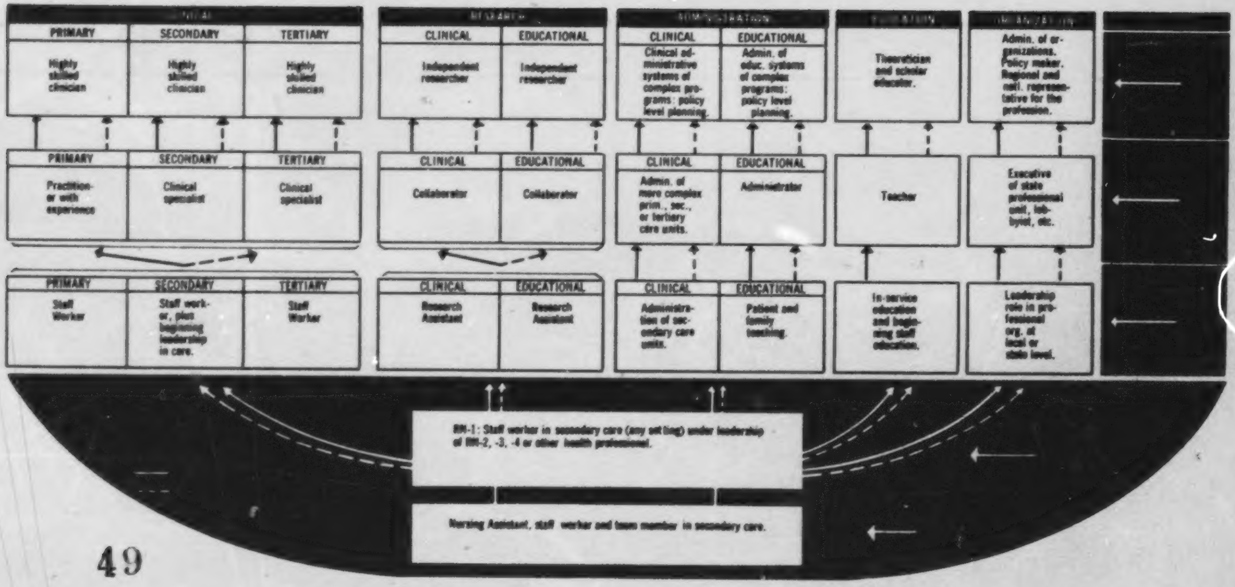

PRIMARY
SECONDARY
TERTIARY
Highly skilled clinician
Highly skilled clinician
Highly skilled clinician
PRIMARY
SECONDARY
TERTIARY
Practitioner with experience
Clinical specialist
Clinical specialist
PRIMARY
SECONDARY
TERTIARY
Staff Worker
Staff worker, plus beginning leadership in care.
Staff Worker
CLINICAL
EDUCATIONAL
Independent researcher
Independent researcher
CLINICAL
EDUCATIONAL
Collaborator
Collaborator
CLINICAL
EDUCATIONAL
Research Assistant
Research Assistant
CLINICAL
EDUCATIONAL
Clinical administrative systems of complex programs: policy level planning.
Admin. of educ. systems of complex programs: policy level planning.
CLINICAL
EDUCATIONAL
Admin. of more complex prim., sec., or tertiary care units.
Administrator
CLINICAL
EDUCATIONAL
Administration of secondary care units.
Patient and family teaching.
Theoretician and scholar educator.
Teacher
In-service education and beginning staff education.
Admin. of organizations. Policy maker. Regional and natl. representative for the profession.
Executive of state professional unit, lobbyist, etc.
Leadership role in professional org. at local or state level.
RN-1: Staff worker in secondary care (any setting) under leadership of RN-2, -3, -4 or other health professional.
Nursing Assistant, staff worker and team member in secondary care.

Figure 5

Future Tracks For Kinds of Nursing Workers

Adapted with permission from *American Journal of Nursing*, June, 1976 issue.

functions are secondary. The profession evolved to serve patients—which means to deal effectively with clinical nursing problems that these patients present" (p. 273).

3. The traditional role of the nurse will continue to be publicly mandated in acute illness settings. To paraphrase and slightly alter Mary Tschudin's definition of nursing (1967), some roles in nursing do not change with age, or geographic setting, or medical diagnosis. Certain activities for nurses in these roles change; certain methods of practice change; but the central purpose of certain roles does not change.

4. When a larger system of primary care services becomes mandated, the knowledge base of each health care occupation will become increasingly shared with other health care disciplines. The knowledge base will overlap because of blurring and coalescing of roles for health care professionals that will occur more frequently—to reduce costs and to increase the effectiveness of existing manpower and thereby services. Moreover, there will be a more rational, optimal, and flexible use of members of all health disciplines.

5. Even now other roles for nursing are emerging in disease and disability prevention, health promotion and maintenance, the care of the aged, the treatment of stress, the teaching of health, and the long-term management of selected chronic diseases.

6. New roles for nurses are also evolving in tertiary care that combine the traditional role of the nurse with the functions of other health care disciplines. In fact, all health care occupations will be experiencing an increasing amount and an increasing rate of change in their jobs, and many of today's health care tasks will be dispersed among a variety of professions and occupations working in a relationship that is coordinate as well as hierarchical. This fact is due as much to changing technologies, the discovery of new knowledge, and changes in population ratios and the nature of the diseases being treated as it is to a shift in emphasis.

7. In the aggregate, nursing practice will include a multitude of workers who will differ in their use of nursing behaviors varying with the setting in which services are given, the nature of control concerning the decision-making process within that setting, and the nature of the client to be served.

8. Entry-level practice will be distinct for graduates of educational programs at different levels in the educational hierarchy. Separate roles for entry-level practice will require more conceptual and human competencies from graduates of upper-division programs.

The schema that appears in Figure 5 was developed to show in graphic form the levels and kinds of nurse providers required for the future in health care delivery practice. The reader is reminded of the assumption that nursing practice is a range of services delivered by separate levels and types of providers who possess different abilities and informational sets upon entry into the system. The plan calls for five different levels of practice and five "pathways to practice" that denote an area of the nurse's major interest and activity.

A linear presentation does not depict a dynamic plan. But the reader is asked to remember that the "boxes" are not mutually exclusive and that the seminar members envisioned movement from box to box and alternatives to conventional patterns.

Levels of practice: The first level of nurse provider identified was the vocational one comprised of people now called nurse-aides, nursing assistants, technicians, and licensed vocational nurses. Whether to include this level of worker was a matter of controversy among the staff, the seminar, and their advisors. Finally it was agreed to place this group on the schema projecting needed workers to show the potential for upward mobility within the range of nursing services. Vocational nurses are likely to enter the RN educational programs as the need for hospitalization lessens and as the market is flooded with vocational graduates.

The project identified four levels of "registered nurse" practice that could be arrayed in five different "pathways to practice." Each of these levels will be described in detail in future sections of this chapter.

Types of practice: Types of providers may be defined by the nurse's clinical interest, the nature of her client, the nature of the services demanded by her clinical interest, the setting in which the services are given, and the behaviors required to give these services. The family nurse practitioner is giving a different type of nursing care than the staff nurse in the hospital. The clinical specialist performs a different service than the staff nurse in community health. The nurse-midwife varies her practice from that of the therapist in psychiatric nursing.

Promotional levels: The task group suggested ways of moving from entry-level practice upward in the hierarchy of nursing positions identified. They believed that competency in clinical practice should be the requirement for promotion from level to level but asked the employer to value and consider as criteria for advancement additional education and experience at the entry-level position. Salary increments, they say, should be based on proficiency and occur within a level, and not necessarily be related to promotion in position.

Titles and labels: The task group found the titles "professional" and "technical" more divisive than helpful in differentiating nurse providers. And the suggestion of "practical" and "professional" seems fraught with even more controversy. The project suggests—but does not recommend—that nurses other than those educated for community health or primary care services be called "secondary care nurses."

Discussion was also prolonged concerning the differences in titles between "clinical specialist," "nurse practitioner," "health practitioner," and "clinician." Some project members believed the terms were synonymous; others, wholly different. The staff suspects that title will follow usage but hopes for a position paper from organized nursing that might clarify our language of titles.

NURSING PRACTICE FOR SECONDARY CARE: THE TRADITIONAL AND CONTINUING ROLE FOR THE NURSE

One of nursing's continuing problems has been the division of responsibility for nursing's tasks among the differing levels of nurse-providers in our hospitals. And you cannot tell which nurse graduated from which program without an employment roster. The client thinks the nurse is the nursing assistant. But the nurse knows that the nurse is often the lady who adjusts the Kardex at the desk in the nursing office. Educational preparation infrequently differentiates the nurse's job responsibilities in many of our secondary and tertiary care centers. Too much is expected of the associate degree graduate and too little of the baccalaureate one. Sister Dorothy Sheahan (1972) pinpointed the real difficulty in this matter when she said that, in fact, "There are several levels of nursing education, but only one level of practice . . ." (p. 442).

But recognizing this barrier to success does not solve the problem of pinpointing and describing an optimal division of responsibility among differing nurse providers in the hospital. The task force describing the kinds of workers needed for future health care practice envisioned the beginning nurse provider—whom they called the RN 1—to be the person working at a staff level in secondary care hospitals and clinics. But it was the long way around Robin Hood's barn to reach this conclusion, as the decision also encompassed the work of other task forces viewing the same dilemma from a different perspective.

The reader will recall the work of an early group in the project's history that defined secondary illness care as being associated with the community hospital and often given in response to single episodes of illness that include the continuing exacerbations associated with many chronic diseases. Secondary care, therefore, addresses itself to illness episodes that are common and recurrent or even routine. The personnel giving this care are less highly specialized and may be defined as generalists attending to illnesses that are usual, expected, and relatively predictable in terms of expected outcomes. Secondary care is widely available geographically.

Three other groups also worked assiduously at defining the characteristics of practice for differing levels of nurse providers in a manner similar to that of the "kind of workers" task force. The initial task of these groups was to define specific nursing behaviors requisite for identifying the differing levels of nursing practice, and, then, as a final effort to synthesize the nurse-provider schema with summary statements describing the characteristics of nurse practice at distinct levels.

Secondary care nursing—a concept coined by the seminar members—is in concert with the definition of secondary care described by the project group at an early seminar. And it is also in congruence with the notions of characteristics of associate degree practice offered by Verle Waters in 1970. In fact, it is Verle Waters' ideas upon which the seminar built its own definition of secondary care.

If the reader assumes—as the project members did—that nursing practice is based on a body of knowledge that has as its core a set of competencies that are universally recognized by nurses as necessary to the provision of the traditional and continuing nursing care in secondary settings, then it follows that a beginning staff nurse having only these competencies has been prepared for the first level of RN practice.

The characteristics of secondary care nursing practice are as follows:

The practice—

—is directed toward clients who are experiencing acute or chronic illnesses that are common and well-defined;

—is directed toward clients who have been identified as being ill or in need of diagnostic evaluation;

—consists of processes that are standardized, in common use, and directed toward alleviating both biophysical and psychosocial health problems, the outcome of which are usually predictable (Waters, 1970);

—includes making nursing judgments based on scientific knowledge that is specific and factual (Waters, 1970);

—is concerned with individuals, but is given within the context of the family and the community;

—is under the leadership of a more experienced staff worker, a generalist clinician, or a clinical specialist.*

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*See taxonomy section for specific behavior identified.

To summarize, secondary care nursing is a word invented by the seminar to describe those behaviors and characteristics of practice traditionally associated with staff nursing in hospitals. But the seminar members also recognized that nursing practice defined as secondary care might take place in other settings. The important consideration is the health care responsibility the nurse is asked to assume in the clinical setting. If her practice in primary or tertiary settings consists of caring for clients who are experiencing common and well-defined illnesses, and if her nursing processes are standardized and in common use, and if the outcomes of her nursing intervention are predictable, then she is practicing secondary care nursing regardless of the environment. But usual setting for this level of practice is the community hospital.

The first level of registered nurse practice is therefore peopled by nurses who enter the system of nursing services prepared to give care to clients; it is an activity that has been traditionally associated with the word *nurse* in illness settings. At entry level the secondary care nurse should be employed to work under the supervision of a more experienced nurse, who can provide leadership and direction for the nursing activities of the novice graduate. The novice nurse may advance in the system of nursing services by demonstrating competency in clinical practice or by advancing her knowledge and skill through continuing, recurrent, or higher education.

The secondary care nurse usually has her educational preparation in a diploma or an associate degree program.

The project recommends that the practice of nursing at all levels be based on a body of knowledge having at its center a set of competencies that are universally recognized as necessary to the provision of secondary care, thus making entry-level practice the common base upon which to build advanced practice.

GENERALIST CLINICIANS*: THE NEW FRONTIER

Bedside nursing in hospitals is "in a precarious state," Esther Lucille Brown said in 1974. Part of the problem lies in high turnover rates among nursing personnel in hospitals, and part of the problem lies in the mismatch of educational values with the hospital's realities.

The baccalaureate degree in nursing is considered the first "professional" degree by many, but the full potential of this graduate has never been realized in hospitals. The reason for this discrepancy, according to Sylvia Carlsen, "is that the clinical laboratories (that is, hospitals) are still functioning on the industrial model in providing patient care (that is, tasks delegated to various levels of workers) which results, as we all know, in fragmented care." Sometimes this functional method is given the name "team nursing." But as Delores Little once said, "Show me a hospital doing team nursing and I'll award them the Nobel Prize in Nursing! By whatever name it is called, the functional approach still results in a medication nurse, an IV nurse, a blood pressure nurse, a bath-giver, and a dressing-changer. Differences in the basic philosophies and objectives of the nurse educator and the hospital service delivery system have caused conflict, and the so-called gap between nursing education and nursing service has resulted in a disruption within our profession. What is taught in our baccalaureate programs is not translated into the service agencies" (Carlsen, p. 7). And at a deeper level, as Esther Lucille Brown observed in 1971, "Some nurses are not interested in patient care in the hospital because of its hierarchically structured systems, with narrow scope for individual initiative of sense of accomplishment" (p. 246). If professional bedside nursing is to survive, Sister Dorothy Sheahan (1972) suggests, then "there is a need for a new type of nurse-client relationship and a new type of nursing authority: such as role congruity between medicine and advanced nursing practice in the hospital unit" (p. 442).

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*The staff does not suggest a new title but prefers the use of words—generalist clinician—to numbers—RN 2.

Tertiary care nursing, on the other hand, has provided the baccalaureate graduate with an opportunity to explore new nursing roles and confine her efforts to delivering nursing services to a small group of clients whose illnesses are defined as a specialty. And the future will require even more knowledges and abilities on the part of these nurses. In fact, the ever-increasing technological capacity to cope with acute illness will require exponential jumps in the sophistication needed to administer care that is intense, immediate, and complex. Even now nurses are making independent clinical judgments formerly made solely by physicians. Nurses in our intensive care services are practicing not only what was formerly thought to be cardiology exclusively but other types of medical specialties as well. Fortunately, hospital backup services are near at hand. And the project anticipates that nurses will continue to give care—at the middle level between what the physician has always done and what the nurse has always done—in post-operative care units for experimental and complex surgery, coronary care units, emergency and trauma units, high-risk newborn units, medical units for the critically ill, and other units not yet thought to be needed. And it is more than gratifying to think that the nursing care given in these units makes such a difference in the client's eventual recovery pattern.

But as the complexity of illnesses treated in our centers for tertiary care increases—as would follow from an active program of health maintenance and disease prevention—a different kind of nurse will be demanded at the entry level, one who is increasingly knowledgeable and competent. Whether this nurse will be the baccalaureate or the master's graduate is still a question to be answered.

Another consequence anticipated from well-planned programs of health maintenance and promotion, disease and disability prevention, will be less client time spent in hospitals. Day care and diagnostic services will be given in health maintenance organizations, physician's offices, clinics, nursing offices, and many acute episodes of chronic disease may be prevented by this health monitoring. The numbers of clients admitted for treatment in secondary care centers are likely to decrease.

Moreover, the care of the non-ambulatory patient who is chronically ill may be administered in an extended care facility known as the "nursing hospital" to be staffed primarily by well-prepared nurses and their assistants. Certainly the care of the chronically ill needing hospitalization—for other than acute illness episodes—is a gap in the system of health care that nurses are suited ably to fill. Referrals to the nursing hospital are likely to be made by physicians or primary care nurses responsible for planning and administering first and continuing client contact in a particular geographic area.

Clients likely to be referred are the chronically ill who:

—cannot adjust to their illness-changed environment;

—require the shelter and protection of institutional care for varying periods;

—need an extended program of health teaching;

—require supportive or therapeutic counseling and shelter.

Other referrals may be the chronically ill whose:

—family cannot adjust to the client as changed by his illness;

—care requires a technology that is impossible to achieve in the home;

—non-acute disease monitoring cannot be accomplished in the clinic or the home.

Nurses working in these hospitals will order their own treatment protocols (nursing care plans), work with families, arrange for supportive counseling, order routine laboratory tests, and admit and discharge clients.

As the aged are becoming an increasing part of the total population, nurses will be assuming a greater responsibility in planning and delivering their care. How ironic it is that the only institution in health care service to be labeled with the name of "nursing" is one in which so few nurses are employed or that the quality of care is often below its maximum potential.

But nurses are beginning to be educated with special information and competencies in the care of the aged, for this segment of health care is literally teeming with potential that nurses have yet to explore. To date, either nurses have assumed the status quo, been too few in number, or too numb to the abuses to think of alternatives to the present structure, but the care of the aged has been under-sung in nursing's agenda for many years.

Esther Lucille Brown (1970) reports the establishment of a program in Oregon whereby interrelated services could be offered in one center: the Benedictine Center for Nursing and Rehabilitation. The idea for the centralization of differing services was enhanced by the parallel development in the department of sociology at Mount Angel College of an institute of gerontology, which became a powerful influence on the thinking of the planners of the Benedictine Center.

> According to the plans projected, the center would be able to offer a program of comprehensive extended care composed of six components: (1) the Convalescent Unit would be designed for patients requiring skilled nursing and/or rehabilitation; (2) Residential and Personal Care, for long-term patients in need of minimal supervision who would benefit from social, recreational, or occupational therapy, or who required personal care; (3) Self-Care, for short-term rehabilitation to help patients achieve independence in activities of daily living; (4) Day Care, for aged patients requiring services not available in their home; (5) Home Care, for discharged patients living within a five-to seven-mile radius of the Center, consisting primarily of nursing evaluation, instruction of family members, and referral to other agencies; and (6) Out-Patient Services, composed of physical and occupational therapy, X-ray and laboratory reports, social work consultation, psychological testing, audiometrics, speech therapy, and so on (p. 173).

But again, the difficulty with nurses' moving into leadership positions in nursing homes is their lack of power—and in this case money—

to become the policy-makers in such organizations. Moreover the deplorable situations existing in many "nursing" homes cry out for nursing intervention of an expert nature in the day-by-day operations of these extended-care facilities for the aged.

The existing situation has gone unameliorated for such a long period in the health history of this country that no less than the Executive Council of the AFL-CIO has recently demanded a nationwide campaign to "clean up this nation's nursing homes," calling them a scandal and a national disgrace (Atlanta *Constitution*, Feb. 21, 1976, p. 45).

Marjorie Stanton admonishes:

> Think what we could do in health care delivery in this country, if baccalaureate graduates were permitted to practice at the optimum level. Have we ever considered the waste of this talent and the resulting deprivation of the public? The fact that we have failed to help these graduates attain their full potential in practice must weigh heavily on our consciences—in both education and service. We are, however, beginning to see a shift in the utilization of these graduates—a shift which we must nurture and encourage.
>
> . . . There are three major changes which will affect baccalaureate nursing education of which we must be aware: (1) national health insurance, (2) third-party reimbursement for nurses—a necessary part of any insurance plan, and (3) full recognition of the potential of the graduate of baccalaureate nursing programs (1975, pp. 3-4).

Projecting the future of nursing practice requires the other shoe to fall—and that other shoe is deciding what level of nurse practitioner will deliver the projected services, either wholly or in part. The "kinds of workers" task force projected the next level of entry into nursing practice to be the generalist clinician, labeled by the seminar members as RN 2. The second level of practice, they envisioned, is peopled by nurses who enter the system prepared to give an advanced level of nursing care as staff nurses in different settings: namely primary and secondary—but tertiary if elected by the nurse during her educational program.

It was an assumption of the project that the knowledge base fundamental to each more advanced level of nursing practice is based on a different set of competencies, each of which is characteristic of its own level and which builds on the core of secondary care nursing: the traditional role of the nurse. Moreover, the body of knowledge expands at each more advanced level of nursing practice and includes different sets of common competencies necessary to the provision of primary, secondary, and tertiary nursing services.

Primary care was defined by the project members as the basic and life-long point of contact for any given episode of illness exclusively, or it may be for the continuous health monitoring likely to take place in a future delivery system. If the nation were to choose a national health care plan, there is no doubt that health care providers would need to realign the person-power to administer the health promotion and disease prevention modalities called for. And for this reason it seemed imperative to the project members that primary care competencies be built into the advanced-level nursing preparatory programs.

Moreover, the project recommended that the baccalaureate curriculum—in the aggregate—be focused on the preparation of graduates to give not only secondary care at the beginning level, but also primary care at the beginning level and—at the student's choice—either primary care at the advanced level, secondary care at the advanced level, or tertiary care at the beginning level.

Primary care nursing at the beginning level was defined by the project participants as having the following characteristics: practice—

—is directed toward providing services for health maintenance and health promotion

  —toward interpreting health for individuals and groups within the context of their sociocultural milieu,

  —toward developing goals with clients that are related to the normal stresses of daily living,

  —toward treating or monitoring clients having selected minor pathological conditions;

—consists of processes that

  —assess the health of normal individuals or clients with minor pathology,

  —screen and either treat or refer clients who are in need of further treatment or attention,

  —manage the long-term care of clients with chronic health problems,

  —teach the basic health promotion concepts;

—includes making independent decisions about health maintenance;

—is concerned with individuals and groups within the context of their sociocultural milieu;

—is concerned with establishing a data base that is interpreted clinically;

—is based on knowledge that is developing and evolving, is future-oriented, contains a moderate level of abstraction, involves critical thinking;

—includes the application of clinical research to decision-making;

—occurs in a setting having consultive and referral services readily available.

Tertiary care was defined by the project as associated with large hospitals and/or medical centers. Like secondary care, it, too, is often given in response to a single episode of illness, but tertiary care deals with the rare and the more complex. One of the seminar members referred to tertiary care as the care of the "super-sick" by the "super-specialized." And the care is often experimental in nature, or at least associated with ongoing research projects of one kind or another. Tertiary care facilities are less widely dispersed geographically so that it is difficult to provide every nursing student—diploma, associate degree, baccalaureate—with tertiary care experience.

Characteristics of practice in tertiary care at the beginning level are given below. The practice—

—is directed toward clients experiencing acute illness episodes and presenting problems that are uncommon, moderately complex, and usually immediate;

—is directed toward clients who have been identified as being acutely or critically ill;

—includes the use of research in making clinical decisions;

—includes making nursing judgments based on the analysis of numerous variables and the prediction of future clinical events;

—consists of the use and development of innovative and less standardized processes that are geared and adapted to the specific needs of clients, outcomes are less predictable and require additional monitoring, and a broader knowledge base is needed from which to draw inferences;

- —is based on a broad range of principles and concepts drawn from a variety of basic and applied natural and behavioral sciences;
- —is based on clinical decisions made from the integration of knowledges of biophysical and psychosocial cues with recognition of their implications;
- —is more self-directive but the nurse recognizes the need for additional information and consultation from peers or higher-level practitioners;
- —is directed toward providing leadership in the management of care for groups of clients as well as those personnel assigned to provide that care;
- —is directed toward developing collaborative relationships with other health workers providing other kinds of services to clients.

For the student electing an area of concentration in primary care, the characteristics of practice are presented below. The practice—

- —is directed toward clients from more diversified populations requiring health maintenance and health promotion;
- —is directed toward clients in a setting where consultative and referral resources are less readily available;
- —consists of processes that are part of a cooperative endeavor to
  - —set the appropriate priorities in meeting the needs of the population being served;
  - —coordinate the total services needed by individuals and groups;
  - —use the appropriate consultation and supervision;
  - —include independent primary assessment such as: history, physical, emotional and developmental diagnostic workup;
- —consists of developing innovative and less standardized processes geared and adapted to meet the needs of individuals, groups, and communities where outcomes are less predictable and require additional monitoring over a longer period of time;
- —includes knowing the nature of the community, the services available and the means of access to those services;
- —is based on a broad range of principles and concepts drawn from a variety of basic and applied natural and behavioral sciences;

—includes making nursing judgments based on the analysis of numerous variables and the prediction of future clinical events;

—includes the application of clinical research to decision-making;

—is based on clinical decisions made from the integration of knowledges of biophysical and psychosocial cues with the recognition of their implications;

—is directed toward providing leadership in the management of care for groups of clients as well as those personnel assigned to provide that care;

—is directed toward developing collaborative relationships with other health workers providing other kinds of care to clients;

—is more self-directive but the nurse recognizes the need to seek additional information and consultation from peers or higher-level practitioners.

CLINICAL RENAISSANCE: COMING OF AGE

The discussions of the seminar members were focused primarily on differentiating workers at entry level for beginning staff nurse positions responsible for secondary or primary care nursing. But graduate education was not neglected. What follows is a discussion of graduate education as it is projected to develop over the next 25 years. The discussion encompasses not only the seminar discussions but a review of the history of role development for the clinical specialist and the nurse practitioner. Some projections envision the accomplishment of the dreams of nursing leaders since the beginning of "professional" schools of nursing in this country. Others portray a future of blurred identity and a new holism in health care delivery.

The assumptions made at the outset of the discussion were as follows:

1. Graduate education will be the initial preparation for the "professional nurse" within the next 25 years—not only because nursing education is following teacher education in this respect, but because the health care delivery system will demand increased knowledges and abilities from nurses.

2. The graduate program in its evolution over the next decade will continue to follow a clinical model more nearly akin to professional schools than to schools of education and liberal arts.

3. Professional education at the master's level will continue—within the next decade—to be based on the undergraduate major in nursing. But generic master's programs in nursing will become the rule rather

than the exception by the year 2000. Eventually the doctor of nursing science degree will be required for entry into advanced nursing practice.

4. Interdisciplinary study and research will be publicly mandated by the year 2000, as no single discipline will be able to solve problems effectively in isolation.

For the present, the project recommends that the graduate curriculum should be focused on the preparation of leaders—clinical and otherwise—to strengthen nursing's contribution to health care. To this end, the project recommends that graduate programs prepare to strengthen quality, expand curricular offerings, and increase enrollments.

The task force defining kinds of nurse-providers needed by the future health care system identified seven roles requiring master's education, namely: the clinical specialist, the nurse practitioner, the clinical researcher, the teacher, the clinical administrator, the educational administrator, and the organizational leader. At the doctoral level this list is similar, but upon reflection the reader will recognize the increased level of expertise: the high-level clinical specialist, the researcher, the educator, the clinical administrator of complex systems, the educational leader, and the high-level policy negotiator and leader. Neither list is exhaustive of the positions available in nursing, but it is suggestive of the project's suggestions of the educational preparation required for various categories of leadership positions in nursing.

The discussion that follows will be confined to a description of the clinical positions envisioned to require graduate education. Characteristics of practice were not developed for other positions by the project's seminar. And because so little time was devoted by the group at large to defining the characteristics of practice for the clinical specialist and the nurse practitioner, a rather extensive review from the literature on functions in role is included. The review is not intended to be exhaustive but to serve as an aid to the curriculum developer working at the graduate level.

Reality or "pie in the sky" mentality? The third level of registered nurse practice may be described as the expanded role of the nurse in clinical practice. In tertiary care settings this role of the nurse is usually called *clinical specialist* and in primary care settings this role is generally called *nurse practitioner*. The seminar members long debated the projected functions of those roles but were unable to resolve their different views about the labeling. Some believed the role functions to be essentially the same, therefore meriting the same name. But others felt that the label *nurse practitioner* had been coined and used by different disciplines to describe a unique role for a nurse in primary care. And another new role may be emerging for the nurse in solo or group practice who moves from setting to setting with a client, much as her counterpart in medicine.

THE CLINICAL SPECIALIST

The role of the nurse clinician is now twenty years old—a gift in concept from the theoreticians in psychiatric nursing. The idea of the clinical specialist has now been well accepted but the work-role has yet to be clarified. What follows is a discussion of the tasks of the work-role as they have evolved over the last twenty years. They are offered at some length as a possible "objective bank" for the curriculum developer.

The analysis of the work-role should begin with Frances Reiter (1961)—the first theorist who defined that role in tasks. She suggests that the clinical specialist should:

1. develop methods for improving the quality of care by—
    - —making her own practice increasingly meaningful;
    - —growing in clinical interest and judgment as well as technical competence to become an expert;
    - —designing and directing the giving of care by other individuals and groups;
    - —becoming immersed in practice so that her nursing intervention, whether it be palliative, supportive, therapeutic, or preventive, encompasses the fullest scope of practice possible;
    - —becoming a staff educator and consultant.
2. study nursing events and support nursing research by—
    - —studying a clinical situation "until she has identified the essence of the nursing problem" (p. 16);
    - —searching for a solution to the problem presented;
    - —conducting a search for a solution in whichever bodies of science are "pertinent, rather than being limited to a set of known principles from one or two general applied sciences" (p. 7).
3. build interdependent relationships among all health-care providers by—
    - —taking a collaborative place on the health team especially in relationship to her colleagues in medicine.

In 1964, Crawford added four new tasks. They are:

1. providing continuity of care for the client—through different settings—to include home, ambulatory clinic, hospital;
2. carrying her own case load of clients and making her own appointments for visits in the clinic;
3. planning and making clinical follow-through visits to the home;
4. becoming a role model for others (p. 32).

In 1965, Hildegarde Peplau suggested the conceptual competencies required in the clinical specialist role. The nurse:

1. "becomes sensitized to problems . . . for which nursing as yet has no definitive answers" (p. 28);
2. "has a broad base of intellectual competencies" (p. 28);
3. "has mastery of methods to analyze problems" (p. 28);
4. knows "how to use a theoretical matrix for observations—for formulating clinical hunches to be pursued in further clinical work or research" (p. 28);
5. knows "how to apply theory and use resources in the solution of problems" (p. 28);
6. "brings a broader matrix of theory that can be used to note problems meriting investigation as clinical nursing research" (p. 28);
7. "develops innovations in practice based on emerging new knowledge" (p. 28);
8. "is a theoretician" (p. 28).

Such a specialist has greater freedom in her practice and can effect clinical trials of new ways to approach nursing problems because she is an expert clinician (p. 25). Therefore, she:

1. "is first of all a generalist . . . so she can do what is expected of the staff nurse" (p. 28);
2. is a model of expertness representing advanced or newly developing practices to the general staff nurse: "a model to beat tradition" (p. 29);
3. works with the "most complex problems" in nursing (p. 29);

4. works with patients and gives direct care to a selected case load, studies and reports her practice (p. 29);
5. has the courage of her convictions and can defend practices on rational grounds (p. 29);
6. functions as an independent practitioner (p. 29);
7. knows how to use "various interpersonal maneuvers" in the process (p. 28).

In relation to studying nursing problems and conducting research, Peplau (1965) says the clinical specialist:

1. not only works with the most complex problems in nursing but also through such work provides a literature which helps constantly to revise the general practice of nursing;
2. uses clinical specialization as a basis for clinical nursing research (As the numbers of clinical specialists increase, clinical nursing research will also increase.);
3. has theoretical and first-hand clinical understanding of the pathology with which she is concerned, keeps abreast of new knowledge that explains the pathology and purpose it serves, checks that knowledge against her own observations;
4. writes clinical papers;
5. keeps track of data in particular situations and reports her findings;
6. disciplines herself to a professional use of her time (pp. 26-36).

Peplau believes that the clinical specialist "makes a good interdisciplinary colleague precisely because she is a sensitive nurse observer, has substantive knowledge, and can talk intelligently with other professionals to share observations and inferences" (p. 26). Clinical specialization is also that "slice of generic nursing" that is "prerequisite for teaching" (p. 26).

In 1965, Luther Christman also spoke of the need for improving the quality of client care, and cited Leo Simmons, who has said that "nurses know more about how and less about why than any other profession" (p. 42). Christman suggested the tasks listed below:

1. assess presenting behavior;
2. make a nursing diagnosis;

3. write nursing orders;
4. become an expert in direct care;
5. establish standards for care;
6. become a role model;
7. become an experiential teacher to other nurses;
8. identify problem areas for study and investigation;
9. possess investigative competencies;
10. write much of nursing's literature.

In 1969, Berlinger, writing on the developing role of the clinical specialist, defined the work-role in a manner that was particularly precise and clear to readers in related occupations. She said the clinical specialist has three commitments: one to clinical practice, one to advancing nursing knowledge, and one to assisting others in developing high-level performances. She continues: "The clinical nursing specialist practices nursing in a clearly defined area, applying specific, relevant theories and knowledges from nursing and its allied disciplines to those persons who require nursing services. The clinical nursing specialist has refined technical skills. Her well-developed problem-solving ability is no longer merely academic exercise, it is an essential intellectual tool of her practice" (p. 102).

But a new twist had been added. "I see the clinical nursing specialist," she continues, "as a counterpart of the clinician in medicine: as responsible for a group of clients on a 24-hour basis; as designing, diagnosing, and planning nursing care; as directing care in some instances or giving care in others; as leaving nursing care orders; as a teacher and model—guiding and counseling others who give direct care; as modifying and adjusting the nursing care plan when a problem arises; as an analytical thinker about decisions; as a goal evaluator; and as a possessor of refined technical skills" (p. 103).

Reiter (1961) referred to the clinical specialist as continually expecting change, as seeking out ways to modify or improve practice, but Berlinger referred to increased involvement of the nurse in changing policy in matters regarding client care. The clinical specialist she described innovated and initiated change. She considered the "unthinkable alternatives," she doubted the "worth of cherished practices," and she had the "freedom to explore her own functions."

The clinical specialist was also a coordinator—a liaison—with other members of the health team and a consultant to those requiring her clinical judgment and knowledge.

Berlinger believed that the clinical specialist contributed to nursing knowledge through research and practice and that she was enabled to do this because she possessed broad intellectual competencies. She kept current of the literature. She identified clinical research problems and researched them. She analyzed and synthesized the existing scientific and humanistic knowledge into the practice of nursing. She had a deep knowledge base.

In 1969, the National League for Nursing published a document describing a clinical specialist as a therapist-practitioner, a teacher-staff developer, a consultant, a researcher, and a change-agent.

In 1972, Virginia Cleland spelled out the goals for clinical specialist's practice as:

1. recognizing and rewarding the practitioner;
2. building interdependent relationships among health-care providers;
3. developing methods for improving care;
4. recognizing that the nurse's responsibility to the client is higher than that to the physician and institution;
5. reorganizing nursing practice to permit the use of social interaction techniques;
6. supporting study and research;
7. seeking greater involvement in decisions about health care priorities and the distribution of monies.

By 1973, the task descriptors were essentially the same—only the language was different. Riehl and McVay (1973) declare the need for a clinical specialist who will:

1. deal with complex nursing problems that are concerned with unknowns;
2. be a leader in improving the quality of care;
3. cope with today's problems and adapt to those of the future;
4. evaluate alternative courses of action and . . . select priorities;
5. create change based on knowledge and wisdom;

6. be expert in the utilization of communication and interpersonal relationship skills;

7. know research methodology and apply this in the clinical setting;

8. know physical and behavioral sciences pertinent to the care of a selected group of patients (p. 50).

But in 1976 nurse educators are still debating the question upon which we remain divided: Is the clinical specialist to be prepared as a specialist, in the way medicine might use the word, or as a generalist? The project members did not agree. Or if a specialist is to be prepared, what are the appropriate areas of specialization? Berlinger (1969) says, "Areas of interest are as confusing as labels and functions. They are sometimes formulated in terms of medical specialties such as cardiovascular and neurology; at times, in terms of developmental specialties such as adolescent and preschool; at times, in terms of theories and concepts such as stress and adaption; and many times, in well-defined practice areas such as nursing care of children, adult medicine, surgical nursing, and maternity nursing" (p. 103). Peplau (1965) also mentioned possible areas of specialization such as the age of the client, his degree of illness, his length of illness, the nursing tasks called for, fields of knowledge, subroles, environmental settings, and clinical services (pp. 22-23).

However, in 1973, report McVay, Riehl, and Chen, there are "two types of nursing specialists seen to be emerging. One is the expert in professional nursing care. This expert is distinguished by her educational preparation, her knowledge base, and her skill in the utilization of the nursing process." Her type of practice "can best be obtained through graduate study that includes nursing content and experience as well as content from the biological, behavioral, and medical sciences." The second type is the expert nurse technician. "This expert is distinguished by her knowledge of specialized techniques in the use of equipment, such as cardiac monitoring, dialysis, and respirator. She generally acquires this knowledge through in-service education and experience" (p. 66).

The seminar concluded that the role of the clinical specialist will become institutionalized into tertiary care centers with the advent of national health care financing. Clinical specialists will increase their capability to give highly individualized care to clients who are acutely or critically ill and who are in need of nursing services beyond the abilities of the staff nurse to administer. They will continue to teach and counsel clients and their families and also peers and staff members. They will assist and monitor the work of other nurses as they develop collegial relationships with others—giving nurses working in bureaucracies that feeling of satisfaction in their work that has been missing from their past work experience.

Nurses in tertiary care centers will continue to collaborate in research with physicians and basic scientists, and—in addition—they will test nursing variables—independently and cooperatively. This will make a unique contribution from nursing to the development of interdisciplinary methods in treatment and care.

In summary it can be said that the practice of the clinical specialist will be directed toward the care of clients presenting multivariant problems that are complex and interrelated. She will be a comprehensive generalist to some and a specialist to others, a model of expertness, a staff consultant and educator, a role model, an experiential teacher, a primary therapist, a consultant, a writer of clinical papers, a provider of clinical literature, a clinical researcher. She works with the most complex problems in nursing, possesses advanced clinical knowledge, improves her own practice, gives and demonstrates care, and plans and supervises staff education. She assists in establishing standards of care.

The practice of the clinical specialist was defined by the project as having the following characteristics: Practice—

—is directed toward advancing nursing knowledge and theoretical understanding by—

  —using a theoretical matrix to formulate concepts for clinical work and research;

  —contributing to the body of nursing knowledge through research and practice by—

    —identifying problem areas for study and investigation; possessing well-developed problem-solving abilities and a mastery of methods to analyze problems,

    —making judgments based on a synthesis of concepts, principles, models, theories to solve complex problems,

    —developing innovations in practice based on emerging new knowledge,

    —evaluating outcomes of nursing intervention,

    —keeping current with the nursing and health care literature;

—is focused on using intellectual, technical, and human competencies that are expert by—

- —possessing first-hand knowledge of the pathology dealt with,
- —being a nurse therapist and expert practitioner,
- —possessing refined clinical skills and assisting others to develop high-level performances by—
  - —giving and demonstrating care,
  - —teaching,
  - —designing, diagnosing needs, and planning nursing care,
  - —modifying and adjusting that plan,
  - —intervening in the client's health-illness process using preventive, palliative, supportive, and therapeutic measures;
- —is interdependent but largely self-directed; the practitioner is—
  - —consultant,
  - —role model to other nurses,
  - —role alter to physician in hospitals,
  - —patient advocate in hospital setting and follows the client to home and return to clinic;
- —is directed toward expecting change, seeking out change, innovating, initiating change, and possessing the freedom to explore own functions;
- —is often directed toward coordinating the total health care plan for the client.

THE NURSE PRACTITIONER

The view that the role of the nurse will change with the nature and scope of other interrelated systems is supported by the development of a new role for the nurse at the borderline between medical and nursing practice. The birth of this role has been fraught with difficulties but is thought by some to be a breakthrough for nursing in its push toward professional status. A brief history of the evolution of this role may be traced in the literature and in the thoughts of our nurse practitioner friends.

Additional definitions of primary care may belabor the point but two more are offered for purposes of clarification.

At the University of Alabama in Birmingham, primary care is defined as (1) a person's first contact in any given episode of illness with the health care system that leads to a decision of what must be done to help resolve his problem; and (2) the responsibility for the continuum of care—that is, maintenance of health, evaluation and management of symptoms, and appropriate referrals. The relationship with physicians may be direct or remote. Nurses practicing in primary care are situated in various settings from urban university centers to the rural areas; for the most part they work in ambulatory settings, such as hospital outpatient departments, physicians' offices, university clinics, and health departments (1974).*

At Texas Woman's University primary care is thought to include the initial point of contact with the health care system and an assurance of continuing contact. Primary health care facilities have been defined as a setting providing services to meet the majority of daily personal health needs. This includes the need for preventive and health maintenance program measures, and for the evaluation and management on a continuing basis of general discomforts, early complaints, symptoms, problems, and stable chronic conditions. Most of the patients using primary care health facilities will be ambulatory, not requiring hospitalization or other in-patient settings, and use the facility as a locus for comprehensive health care service (1974).**

The nurse practitioner is a member of a health team, according to Texas Woman's University, that serves as the first contact for individuals and families seeking services, facilitating their access to health care and to the whole health system. She provides care to clients at the middle level—between that of the skilled community nurse and the family physician. The nurse practitioner uses her nursing background and skills in counseling, guidance, and health instruction, and provides an intensive service in health assessment, diagnosis, and treatment of frequently occurring illnesses. She is responsible for the clinical management of those cases that fall within the scope of her competence. The nurse practitioner may also coordinate the care given by various medical specialists and community agencies.

Controversy has arisen among nurses and physicians over the use of the words *nurse practitioner*. Some claim that every nurse who practices is a nurse practitioner, but common usage says that the nurse practitioner is one who has expanded the traditional nursing role and assumed increased responsibility and independence in providing primary health care for individuals and families.

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*We are grateful to Isobel H. Thorp, Director of the Pediatric Nurse Practitioner Program at the University of Alabama in Birmingham, for supplying this information.

**We are grateful to Edith Wright, Director of the Family Nurse Clinician Project at Texas Woman's University, for supplying this information.

In 1965 the first formalized program for nurse practitioners—the pediatric nurse associate program—was developed at the University of Colorado School of Nursing in Denver. Since that time many more programs have been established throughout the country aimed at preparing not only pediatric nurse associates but also family nurse practitioners, maternal-infant practitioners, family planning practitioners, and the like. But the preparation for the role is not yet institutionalized into either baccalaureate or graduate programs in nursing. The programs vary in length and format from intensive on-the-job preceptorships to two-year graduate programs that prepare nurse clinicians.

The program developed in Colorado was designed to expand the traditional role of the pediatric nurse. Its aim was "to prepare professional nurses to furnish comprehensive well child care to children of all ages, to identify and appraise acute and chronic conditions and refer these patients elsewhere as indicated, and to evaluate and temporarily manage emergency situations until needed medical assistance becomes available" (1967, p. 1443).

Students in the program were assigned to field offices to:

> —increase their ability to assess the physical and psychosocial development of well children;
>
> —study the variations of growth patterns;
>
> —learn to perform developmental tests and such evaluative procedures as—
>
> > —history-taking,
> >
> > —complete physical examinations,
> >
> > —[and a] limited number of laboratory procedures;
>
> —counsel parents in child-rearing practice;
>
> —carry out immunizations;
>
> —augment preventive health services;
>
> —[and] increase the amount of child health supervision in the communities in which they practice (p. 1444).

Some of the questions answered by the success of this program were (1) will clients and parents accept the nurse practitioner? (2) will the time of the physician be conserved? and (3) will the children receive adequate health care? Fortunately for all involved—nursing, medicine, children—the answers were a resounding *yes*. But the questions continued to pervade the thinking of both physicians and nurses.

In pursuit of the answers, Andrews and Yankauer (1971) reviewed the literature on nurse practitioners for the time period 1963 to 1970, confining their search to pediatric ambulatory care settings where nurse practitioners were practicing in group practice with physicians. They found that children receive "at the very least equivalent care," "parents and staff acceptance is good," and "the physician's time is conserved."

> —California, 1963: "Parents liked the concept of the expanded role of the nurse, but physicians and some nurses were less accepting;"
>
> —California, 1968–69: Concept and practice of expanded role "caught fire" and is now widely accepted in state's public health services;
>
> —New York (Montefiore), 1966: "Use of experimental and control groups; experimental group parents accepted the nurse well and were slightly more satisfied with the care they received than control group parents;"
>
> —Colorado, 1967: "Silver found that 71 percent of all patients' visits to an urban neighborhood health station could be handled by a nurse practitioner alone. About half the children were well, half ill. For another 11 percent, the nurse required telephone conversation with the physician, while in the remainder, the patient was referred to a physician or medical facility for further care" (pp. 505–6).

Nurses functioned well in these roles because, as Mereness emphasizes, "many functions and other aspects of the pediatric nurse practitioner role are not revolutionary or new to nursing theory. Indeed, basic nursing education is now increasing the preparation of nurses in health maintenance skills. However, the health care system in which a nurse is placed has not, until very recently, allowed her to use her potential" (1970).

Fahy (1973) identified nine areas composing the scope of medical practice. They include the practitioner's ability to:

1. take a thorough medical history;
2. perform a complete physical examination;

3. develop a differential diagnosis;
4. perform a variety of diagnostic tests and procedures;
5. reach a specific diagnosis;
6. prescribe a plan of care;
7. counsel parents and families in regard to health maintenance and teaching (nutrition, personal hygiene, medical management and maintenance);
8. recognize forces and resources in a given community that assist or inhibit individuals and families in coping with their on-going health-illness problems;
9. identify social and psychological factors inherent in health-illness situations that serve as components of the problem.

She continues by stating that "except for the last two, all of the above nine have been hitherto thought to be the prerogative of the physician to a greater or lesser extent." Now it is "believed that the first four can be carried out by three individuals within the health care industry": the physician, the physician's assistant, and the nurse practitioner. "It is my further contention," asserts Dr. Fahy, "that functions five through nine are best carried out by two groups—physicians and nurses—in an interdependent, collegial, and collaborative manner. This will require definitive overlapping and collaborative education in hard sciences, soft sciences, socialization processes, clinical preparation, and skills training" and "it is in the realm of strategies for sharing and educating for them that the battle of dependence-interdependence will be hammered out" (p. 49).

The seminar members projected that the traditional role of the community health nurse will expand to include some but not all of the following for the individual practitioner of nursing:

—assessing the health-illness status of clients by—
    —securing and recording a complete health history and critically evaluating findings,
    —assessing individual and family health needs;
—performing a complete physical examination using the techniques of observation, inspection, auscultation, palpation, percussion, and communication;

—developing a differential diagnosis by discriminating between normal and abnormal findings in health history and physical assessment;

—performing selected diagnostic tests and procedures, such as hearing tests, pap smears, pulmonary function tests, selected laboratory diagnostic tests;

—reaching a specific diagnosis, deciding which persons can be served by nurses and which ones are to be referred to physicians and other agencies;

—prescribing a plan of care;

—monitoring client's health under plan prescribed, such as—

  —common medical problems: otitis media, sore throat, conjunctivitis, infant and adult gastroenteritis, pneumonia, urinary tract infections, common skin disorders,

  —stable phases of chronic illnesses: diabetes, chronic obstruction, congestive heart failure, arthritis, hypertension, arteriosclerotic disease,

  —uncomplicated ante- and post-partum care: provides counseling and guidance to the client and assists in the selection of appropriate contraceptive,

  —care of minor accidents to include suturing;

—counseling and teaching clients and families: health maintenance, nutrition, personal hygiene, medical management, management of emotional stress;

—acting independently in meeting health needs through anticipatory guidance and relevant health teaching to promote optimal physical and mental health and to prevent illness;

—recognizing forces and resources in a given community that assist or inhibit individuals and families in coping with their ongoing health-illness problems;

—identifying social and psychological factors inherent in health-illness situations:

  —observes and evaluates the client's emotional condition,

  —recognizes behavior and attitudes that influence individual and family health,

  —counsels and supports individuals and families;

—coordinating health management:

- —collaborates in devising ways to deliver health care,
- —advocates clients' interest from home to clinic to hospital,
- —makes home visits, school visits, visits to industries,
- —cares for the aged: conducts clinics, visits home and extended care facility.

CHAPTER 4

A Taxonomy of Nursing Competencies

The collocation of kinds and types of nurse-providers matched to corresponding sets of nurse behaviors was derived from a model of nursing practice adopted early in the deliberations of the seminar. The model was based on old and new ideas and then synthesized into a paradigm that could be used for planning curricular structure. (Please see chapter 2 for a discussion of the model.)

It was assumed by the participants that the nursing role could be broadly classified into sets of behaviors known in the aggregate as the nursing process. Moreover, each service occupation has like procedures that can be categorized into a process for appraising the client's presenting problem, deciding upon a remedy, devising a strategy for administering the remedy, and evaluating the results of its application. The question facing the project participants was how much of this process is essentially cognitive, how much affective, and how much technical proficiency. In addition, the emerging role for the nurse practitioner has raised a further question of where the borderline between medical and nursing practice lies. Will the nurse continue to be engaged predominantly in giving "care", as she always has, or will her functions now extend to cure, the traditional province of the physician?

But the care-cure dichotomy is a false one because care is an important part of the province of the physician also. Thomas (1972) observed as a physician that:

> Now that science has entered medicine in full force, we must begin to sort out our affairs. From now on we will need, as never before, to keep these central enterprises—to cure, to relieve, to comfort—clearly separated from each other in our minds. They do not really overlap, but we tend to view them—and the public, of course, takes the same view—as though they were all of a piece, all the same body of technology, all derived from science, all modern . . . [and] . . . we do not like to confess to ourselves that so many of the things that we do are provided simply for comfort and reassurance. Somehow, these have come to seem less significant products than a cure, so we try, consciously or unconsciously, to pretend that there is more continuity than is really there, that everything we do is directed toward the same end (p. 32).

Instead of the usual dichotomies—such as the care-cure one mentioned above—it is more helpful to think of the activities of the person practicing in a service occupation as a process, such as, in the case of nursing, the nursing process, or in the case of medicine, the therapeutic process. Each health care discipline differs from the next in the scope of those activities it considers central to its work, but there is no doubt that many activities and purposes are shared. Each profession appraises the client's presenting problem, decides upon a solution, devises a plan for accomplishing the remedy selected, implements the plan, and evaluates its application.

The nursing process is well enunciated in the National League for Nursing's publication entitled *Characteristics of Baccalaureate Education in Nursing*. For example:

> —*assess*, *plan*, *implement*, and *evaluate* nursing care with clients—individuals, families, communities.
>
> —utilize theoretical and empirical knowledge from the physical and behavioral sciences and humanities as a source for *making nursing practice decisions*.
>
> —utilize decision-making theories in determining care *plans*, *designs*, or *interventions* for achieving comprehensive nursing goals.
>
> —treat nursing interventions as hypotheses to be tested; *anticipate* a variety of *consequences* and *make predictions;* and *select* and *evaluate* the effectiveness of *alternate approaches* (p. 1; italics ours).

The rendering of the nursing process into specific behaviors—intellectual, human, and technical—was a task the seminar members diligently pursued during much of the time they spent together. The immediately following sections of this chapter present their work (edited and sometimes rearranged by staff and consultants).

CONCEPTUAL COMPETENCIES

The ability to use intellectual processes differentiates—more than any other variable—the beginning worker from one who enters the system at a higher level or advances to higher levels via relevant clinical experience. The task force that described the varying levels of conceptual competencies profoundly felt that the ability to use intellectual processes was enhanced by the acquisition of meaningful information subsequently called by them the "knowledge base." The cognitive process, they concluded, is the same for all levels of nurse-providers but it is enhanced by knowing what clinical cues to observe, how their configurations are important, what probable inferences to make about them, what nursing strategies will correct an unbalanced physiological or emotional state in the client, and how to evaluate the effectiveness of the nursing activities selected. And it is this distinction—this knowing—that differentiates the separate levels of nursing practice.

Essentially there are two—and maybe more—ways of knowing used by the nurse in performing clinical services. The first may be thought of as theoretical, that is, the ability to reason from necessary relations between a configuration to a subset of lesser cues or ideas. If the observer possesses sufficient theoretical knowledge, well-grounded in fact—if, indeed, he or she is so confident of the relations between the configuration and the relevant subset as to argue that the system and the subsystem have a necessary relation—upon observing the subsystem she may assert that the configuration is present. This is a form of deductive logic, and the argument is just as good as, and no better than, the knowledge on which it is based. Inductive logic is also used but less frequently in clinical events and situations of an immediate nature.

The description of this kind of "theoretical" knowing is generally familiar to curriculum workers via Bloom's taxonomy.

Drawing liberally from this source, the task group defined conceptual competencies as the learned ability of the nurse to perform those activities that:

—recognize cues in the clinical event;

—identify needs and resources;

—analyze and synthesize knowledge into clinical decisions and evaluative processes into new understandings and new ways of conceptualizing events and situations;

—create new knowledge and new processes.

These abilities may be broadly classified into measures for—

—seeing, observing, and recognizing behavioral, physiological, and environmental cues;

—appraising, assessing, or criticizing cues on the basis of standardized criteria and norms;

—making inferences using problem-solving methods to include distinguishing, classifying, and relating hypotheses to data;

—using units of information to analyze and interpret data, to recognize patterns and relationships, and to predict outcomes;

—evaluating feedback data by appraising, assessing, or criticizing on the basis of criteria, norms, and desired outcomes;

—developing new remedies, action plans, or hypotheses to include creating, originating, and integrating ideas and proposals that are new.

	ADN	BSN	MSN	DSN
CONCEPTUAL COMPETENCIES: GENERAL				
Recognizes Information				
Description of events	▬	▬	▬	▬
Generalizations	▬	▬	▬	▬
Facts	▬	▬	▬	▬
Laws-principles-concepts	▬	▬	▬	▬
Theories-models	▬	▬	▬	▬
Uses Information				
Understands (compares, paraphrases, translates, interprets) information concerning:				
descriptions of events and situations	▬	▬	▬	▬
generalizations	▬	▬	▬	▬
facts	▬	▬	▬	▬
laws-principles-concepts	▬	▬	▬	▬
theories-models		▬	▬	▬
Manipulates Information				
Employs problem-solving methods:				
using several cues	▬	▬	▬	▬

	ADN	BSN	MSN	DSN
Manipulates Information (cont.)				
using many more cues		■	■	■
using complex cues			■	■
emphasizing intersystem conceptualizations				■
Selects data to be collected:				
traditional and routine	■	■	■	■
above and beyond routine		■	■	■
goes beyond information readily available			■	■
Uses data selected:				
as prescribed	■	■	■	■
above and beyond prescription		■	■	■
Forms ideas and hypotheses concerning data	■	■	■	■
Tests fit of data to event or situation:				
simple tests and constructs		■	■	■
tests many more alternatives and constructs			■	■
complex tests and constructs				■
Evaluates feedback data*				
Analyzes Information				
Classifies and categorizes			■	■
Distinguishes between			■	■
Relates hypotheses to data			■	■
Realizes probabilistic sense of knowledge			■	■
Appreciates the concepts of time, space, depth, as they apply to knowledge			■	■

---

*At varying levels of complexity as suggested in the characteristics of practice, above.

	ADN	BSN	MSN	DSN
Synthesizes Information				
Creates new knowledge				▬
Originates new ideas, models, theories				▬
Integrates information into hypotheses and proposals that are new				▬
Forms new insights				▬
Evaluates Information				
Appraises, assesses, and criticizes on basis of criteria and norms of a scholarly notion				▬

But the taxonomy given above also applies to situations that are not clinical in nature, and deductions and values are much better stated in educational texts concerning curriculum development. In fact, the reader is advised to consult a copy of Bloom's (1956) taxonomy while considering the deductions given above.

The conceptual competencies task force also considered the work of Kenneth Hammond on clinical inference in nursing; the reader is referred to his several articles in *Nursing Research* for fuller clarification of his views. Dr. Hammond also assumes that the amount of information available to the nurse is the most important factor in her ability to make clinical decisions and suggests that the inference process is similar to that of the Brunswick lens model of cognition.

Dr. Hammond believes (and the staff hopes it is not oversimplifying his ideas) that the client presents himself for a clinical service that may vary over the entire continuum of nursing services, that is, physiological or psychosocial disequilibrium, health promotion, disease monitoring, counseling, or health teaching, to name a few examples. He also believes that the nurse assesses the client and his need for nursing services on the basis of a broad or narrow range of cues. How many cues the nurse can assess is dependent upon her knowledge base, her perceptual abilities, and her competency to relate the cues the client is presenting to what she knows. The nurse also assesses the interrelationships of other presenting variables as they may influence the client's state of health or illness, that is, sociocultural factors, environmental factors, developmental factors, or other relevant variables that she may recognize. The presenting problem, therefore, may be interpreted as simple or complex depending on the number of cues she perceives and her ability to evaluate their meaning and implications.

After assessing the cues—which the nurse compares to her information store about them—she makes an inference about their interrelationship (a configuration) and about the nature of the remedy (if any) that will be required to relieve the client of his discomfort, maintain and promote his health, restore his state of equilibrium, or monitor his chronic disease.

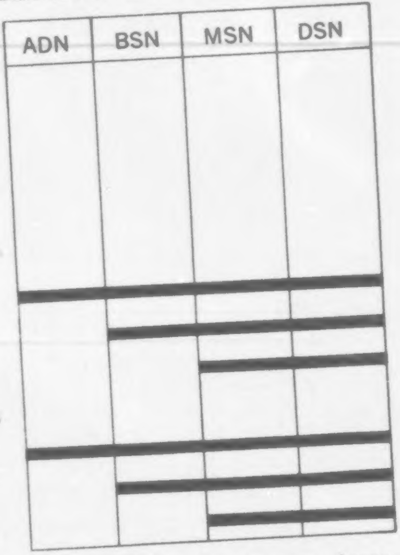
She then acts to implement that decision which may involve the use of her technical competencies. It is this acting that is thought by many health care administrators, and consequently the public, to be nursing practice. But it is only one part of the process and not necessarily primary at that. Her decision may involve the "laying on of hands" but is likely to involve her humanistic competencies as well. The nurse then evaluates the effectiveness of her actions—a totally cognitive process—upon the client's welfare and makes changes in her own or the client's activities if the desired result is not forthcoming.

CONCEPTUAL COMPETENCIES: SPECIFIC FOR CLIENT AND HEALTH CARE AGENCY

Recognizes Cues
(synonyms: appraises, assesses, observes, perceives)

Behavioral events and situations
- beginning information sets*
- larger knowledge base
- complex knowledge base

Physiological events and situations
- beginning information sets
- larger knowledge base
- complex knowledge base



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*That is, a small range of cues that are common and well-defined; please see characteristics of practice for secondary care for additional criteria. In fact, the characteristics of practice at varying levels can be used as a guide to measure the complexity intended by the taxonomy writers.

	ADN	BSN	MSN	DSN
Recognizes Cues (cont.)				
Environmental events and situations				
beginning information sets	▬	▬	▬	▬
larger knowledge base		▬	▬	▬
complex knowledge base			▬	▬
Intrasystem relationships				
individual	▬	▬	▬	▬
small groups		▬	▬	▬
complex systems			▬	▬
Intersystem relationships				
simple interdisciplinary teams	▬	▬	▬	▬
larger interdisciplinary teams		▬	▬	▬
complex agencies and organizations			▬	▬
Compares Cues, Events, and Situations to Learned Criteria				
Descriptive data (norms, demographic)	▬	▬	▬	▬
Generalizations	▬	▬	▬	▬
Facts	▬	▬	▬	▬
Laws-concepts-principles	▬	▬	▬	▬
Theories-models		▬	▬	▬
Identifies				
Needs				
within a system†				
between systems†				
resources currently present†				
Constraints				
within systems†				
between systems†				

---

†With varying levels of complexity as described in the characteristics of practice, above.

	ADN	BSN	MSN	DSN
Identifies (cont.)				
Potentials				
within a system†				
between systems†				
Values				
within a system†				
between systems†				
Decides On (Inference)				
Working theory for problem presented and compares to				
descriptive data	■	■	■	■
facts	■	■	■	■
generalizations	■	■	■	■
concepts-laws-principles	■	■	■	■
theories-models		■	■	■
Determines alternatives and remedies				
intrasystem†				
intersystem†				
Determines plan of action				
goals and purposes†				
specific strategies†				
need for adapting or modifying usual solution to event or situation†				
sequence of action (factoring)†				
priorities†				

---

†With varying levels of complexity as described in the characteristics of practice, above.

	ADN	BSN	MSN	DSN
Predicts (Goes Beyond Information Given)				
Anticipates outcomes				
within a system			▬	▬
between systems			▬	▬
Develops				
New or different ideas and proposals				
within a system			▬	▬
between systems			▬	▬
Evaluates Feedback Information From Cues, Events, Situations				
Behavior†				
Physiological†				
Environmental†				
Within a system†				
Between systems†				
Creates New Knowledge				
Ways of conceptualizing				▬
Ways of doing				▬
Principles-concepts-theories				▬
Models				▬

---

†With varying levels of complexity as described in the characteristics of practice, above.

The seminar's task group on conceptual competencies made the following assumptions:

1. The cognitive process is profoundly affected by the complexity of the nursing events or situations with which the nurse must deal. Consequently, the clinical specialist requires more information for her practice than does the beginning practitioner in secondary care. So it can be assumed that the larger the amount of relevant information possessed by the nurse, the more will be her ability to deal effectively with complex variables in any situation. Complexity varies with:

—the nature of the client,

—his place in the health-illness continuum,

—whether the client is an individual, group, organization, community,

—the nature of control concerning the decision-making process,

—the number of systems or subsystems involved in the decision,

—the settings for services.

(Please see chapter 2 for definition of the client and the project's model of nursing practice.)

2. The duration of the effect of the nurse's intervention is also a factor in the cognitive process. Consequently the larger the range of information processed by the nurse, the greater will be her ability to deal effectively and simultaneously with the many complex variables in any nursing event, and to predict and manipulate both the immediate and long-term effect of her intervention. She knows the half-life of information. Moreover, the smaller the knowledge base possessed by the nurse, then the more circumscribed is her ability to predict and manipulate the nursing event for the betterment of her client's welfare as a result of her intervention; therefore, she tends to deal with the immediate and the concrete.

3. As is stated in the taxonomy, the task force members felt that the amount of information known to the nurse—if large—would enhance her ability to suggest hypotheses and alternative courses of action and consequently her skill to differentiate among them. And the more flexible her cognitive style, the more methods of inquiry known to her, then the more likely she is to suggest new proposals, to plan alternatives, and to recognize constraints.

4. In clinical practice it cannot be forgotten that cognitive behaviors—resulting in functional and human behaviors—have consequences for the client that range from the optimal to the disastrous. Therefore, it was assumed that more information will lead to more ability to predict consequences in a variety of health care settings. Prediction of the impact on the client of the nurse's decision varies with—

—the nature of the client,

—the time involved (immediate to long-term) in the nursing event,

—the energy and money expended or required,

—the resulting or concomitant trauma (physiological, emotional, ecological),

—the social consequences of the behaviors of those persons and institutions at issue.

5. The personality attributes of the practitioner also influence the cognitive process, although less for immediate than for long-term decisions and predictions. Persons vary in cognitive style from relational to holistic thinkers. Thev also vary in their ability to influence others or to attract them to a particular program by their charismatic ways. Creativity also varies from nurse to nurse but affects her decisions and planning profoundly.

6. The environmental setting often determines the need for a nurse with more or less conceptual abilities. It is the range of cues that the nurse must assess, both in number and diversity, that determines which nurse should be doing what in the environmental setting:

—the less the number of cues to be evaluated, then the less information the nurse requires;

—the more open and flexible the cognitive process of the nurse, then the less need for a structured environment;

—the more probable outcomes she knows, then the more willing she will be to take risks.

7. The larger the knowledge base possessed by the nurse, the greater will be her ability to increase her—

—span of responsibility

—perception of reality

—understanding of the varying relationships among subsystems and therefore her ability to intervene and manipulate factors to reach more optimal states.

> We must understand what man is. . . . To understand him is to understand the world, for he is similar to the world in his construction. He is the microcosm, the macrocosm in miniature.
>
> —*The Carada Samhita*

HUMAN COMPETENCIES

The human abilities requisite for nursing practice were identified by a special task group of project members composed of both educators and practitioners. Their interests varied, their settings for practice differed, and their teaching expertise was divided among the existing levels of nursing education. This group met several times during the course of the project—often generating heated discussions—and culminated their efforts only last year at an all-day meeting. The group insisted until the very end that the human abilities of the nurse could not be separated from the intellectual and functional ones even for purposes of study, but agreed that their end product was a worthwhile document from which others could benefit, if only in a heuristic way.

The task force defined human competencies as learned abilities or given aptitudes to perform interactive behaviors that are designed for the facilitation of self or others in a particular environment. Human abilities, the task group said, are a vehicle for personalized implementation of intellectual and technical competencies, and they often cannot be accomplished apart from them. To phrase this idea in another way, it might be said that human abilities are a synergistic process through which intellectual competencies are merged with technical behaviors and become humanized.

These abilities may be broadly classified into measures for:

—interpersonal interaction (between two or more persons);

—intrapersonal interaction (between the cognitive and affective self).

Interaction occurs with or without overt communication and it creates change at varying system levels in individuals, groups, organizations, communities, or even larger systems.

Specifically human abilities consist of the use of the self to:

- —develop a sense of trust and comfort in an interpersonal relationship;
- —develop empathy for and acceptance of the other's behavior;
- —communicate with others;
- —establish mutual and reciprocal working relationships with clients.

The assumptions made by the task group working on the taxonomy of human competencies are:

1. Human abilities can be learned by increasing the amount of information known to the nurse, by trial and error or experiential learning, by imitation of models, or by other relevant ways, but the selfsame abilities are internalized by the nurse at a higher level of cognition. Intellectual knowing is one thing, pathos another, but both are involved with developing a relationship significant to the participants.

2. One of the variables concerned with the internalization of knowledge and pathos by individuals is a cognitive screen through which the nurse's observations must pass before they are charged with meaning. Therefore, it seemed rational to believe that the more holistic the understanding of the human condition possessed by the nurse, the more open the screen, then the greater her ability to deal with the complexities of intra- and interpersonal interactions. Complexity is determined by:

- —the nurse's sensitivity to self and others;
- —the nurse's flexibility, particularly as it relates to her ability to assess persons and situations and to recognize alternative methods of crisis or problem resolution*;
- —the nurse's tolerance for ambiguity;
- —the nurse's ability to communicate with others both overtly and covertly.

3. Another of the variables concerned with the internalization of pathos by individuals is once again a perceptual one. That is to say, the more the nurse is able to conceptualize life's small moments and developmental eras from the viewpoint of the other, to relate to the

---

*The task group suspected that this variable was related to Rokeach's "open and closed mind" notions about personality.

other in his own frame of reference, then the more will be her ability to create an interpersonal relationship that is meaningful to the client.

4. Emotional maturity is another cogent factor in the development of human abilities. The less egocentric the needs of the nurse are, the less defensive she is, then the more is her desire to help others, to find self-realization in her own thoughts and actions, and, consequently, the more is her ability to relate to others in a manner that is warm and positive.

5. The more positive the self-concept of the nurse, the more knowing and accepting she is of her own behavior, the more she recognizes her own capabilities and limitations, then the greater is her ability to interact comfortably with others and have them respond in a like manner.

6. Another of the often overlooked factors concerned with the development of human abilities is the nurse's value system. The more humanistic the mind-set, the broader the value system, the greater the respect the nurse has for the human condition (including man's potentials and limitations), the greater her capacity for causing a positive change in the thinking and behavior of the other.

7. The need is paramount for the nurse to remain as objective as possible in her observations of behavior and in her interpretation of situations. It was assumed, in fact, that the more the nurse is able to divorce herself from current social constraints or prevalent and faddish theories of behavior, then the more open she could be in interacting effectively with the other.

8. The nurse is more able in human abilities when she recognizes her own self-boundaries (i.e., recognizes her own feelings and distinguishes them from those of others, describes her own likes and dislikes, expresses her own value system and personal goals) and is open to experience without being threatened or overwhelmed.

9. Students learn human abilities in a hierarchical fashion. They first learn comfort and courtesy measures, and with this learning they become more aware of themselves as persons. Their awareness further increases as they learn to be empathetic and accepting of the other's behavior. It is only then that the learner can begin to establish mutual and reciprocal interpersonal relationships that are the therapeutic tools for helping the other. Graphically this process is shown in Figure 6.

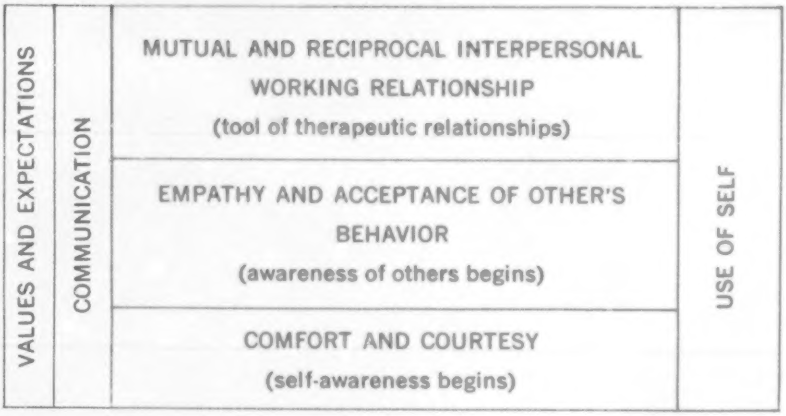
VALUES AND EXPECTATIONS
COMMUNICATION
MUTUAL AND RECIPROCAL INTERPERSONAL WORKING RELATIONSHIP
(tool of therapeutic relationships)
EMPATHY AND ACCEPTANCE OF OTHER'S BEHAVIOR
(awareness of others begins)
COMFORT AND COURTESY
(self-awareness begins)
USE OF SELF

Figure 6

> . . . Basic programs tend to look at the liberal arts courses mainly in terms of how much knowledge can be "used" in nursing, rather than as liberalizing, humanizing influences that stretch the minds and thought of the students.
>
> —Hildegarde Peplau

We educators know very little about how human abilities are learned; our assumptions about these matters are therefore very much colored by the schools we have attended or the personality theorists who have spoken to our own unique psychic needs. The task force working on identifying human abilities often reached impasses in ideology, but in retrospect it is more than interesting to compare the assumptions of this group with those of Arthur W. Combs at the University of Florida.

For more than twelve years the psychology department at the University of Florida has produced a series of research studies on good and poor practitioners in the various helping professions, including college and public school teaching, nursing, counseling, and the relationship of priests to parishioners.

Dr. Combs (1971) reports that:

> In our research we found clear differences between the good helpers and the poor ones on the basis of their beliefs about five major areas. The first was their beliefs about the important

> data to which they ought to be attending. The good helpers are always concerned about the phenomenological question, how things look to the people they are working with. The poor helpers are concerned about the subjective question, how things look to them. Second, the good helpers can be clearly differentiated with respect to how they see people. It makes a lot of difference what you believe about people, and we found clear differences in this category. Third, we also found that the good helpers can be quite clearly distinguished from the poor ones on the basis of how they feel about themselves. The good helpers feel positively about themselves, and the poor ones feel negatively. Fourth, we found that you can also tell the difference on the basis of their purposes; there are quite clear differences in the purposes of the two groups. Finally, we found a difference on the question of methods—not on what kinds of methods, but on the authenticity of the method for the particular person who was using it; quite a different question from "right" methods (p. 4).

The manuscript prepared by Dr. Combs was found by the staff after the work of the human abilities task group was completed, but it is interesting to note the similarities not only in the conclusions but in essential questions. The Florida researchers concluded that "what makes a good helper is not necessarily knowledge" (a statement with which some task group members might not agree). "You cannot tell whether a person will be a good helper or not on the basis of the information he possesses. There are many teachers who know their subject but are not good teachers. So the question of becoming a good helper is not a question of knowledge . . ." (p. 1).

He continues,

> We have to understand that learning is not just a question of new information. Learning has to do with the deeper and deeper discovery of the meaning of information [a statement with which all task group members would agree]. Often it has nothing to do with new information. For example, I remember years ago when I was a student with Carl Rogers, writing down in my notebook a statement about counseling that said, "the counselor must have an absolute respect for the dignity and integrity of the client." You know, I haven't learned any new information about that in 40 years, but every day I discover the deeper and deeper meaning of this which I already

> knew. Or, take the basic principle of the brotherhood of man; few of us need more information about this concept. What each of us needs is the personal discovery at ever deeper levels of the meaning of that idea (p. 20).
>
> If it is true that what makes a good helper is a problem of his beliefs, then what we have to emphasize in our [teaching] . . . is meanings rather than facts. People don't behave according to facts; they behave according to their meanings. They behave in terms of what seems to them to be true, in terms of their beliefs. This is the basic principle of perceptual psychology. We have to recognize that human behavior is only a symptom. The behavior you see is only a symptom—the causes lie within the person . . . in the person's personal belief system (p. 8).

Another factor, Dr. Combs reports, has to do with how the person sees himself.

> We found in the Florida research that good helpers see themselves in essentially positive ways while poor ones see themselves in negative ways. One who has done any reading in American psychology these days must be keenly aware of the importance of the "self-concept". We know it is perhaps the most important single determiner of a person's behavior, yet it is almost completely ignored in most educational systems. If the self-concept is so important, as it seems to be in the research, then we are going to have to help [students] to see themselves in more positive ways.
>
> This brings us to a very interesting current fallacy. Because of all the emphasis on the self-concept, some people have been led to the assumption that if you want to help a person change himself, the thing to do is have him examine himself. So, many programs spend a great deal of time in having young helpers indulge in self-examination. I would like to suggest to you that the way to get a person to change himself is *not* to get him to look at himself. Why? Because how a person behaves is a function of how he perceives, but how he perceives himself is not something *he* decides. He learns who he is from the feedback he gets from out there. So having him examine himself often does little more than to help dig himself deeper into his morass (pp. 13–14).

And the last notion called to the attention of the educators by the research was the need to

> . . . understand clearly the distinction between practitioner and scholar in trying to produce effective helpers. The scholar is content to learn *about* a question and be able to give it to other people. For the scholar, the major thrust is through exposure to ideas usually through reading, lectures, demonstrations, things teachers do to us or for us or insist that we do for ourselves (p. 20).
>
> But the problem of the practitioner is a different one. The problem of the practitioner is not just to know—he has to do something with it. He has to put it to work. That requires a quite different educational experience from that of the scholar.
>
> It requires that the practitioner must get involved in his subject matter. It means he must be continuously engaged in dialogue, and in that discussion there may even be need for more information. It is interesting, however, how brainwashed most students are in this respect. They come to us in colleges believing that they aren't learning anything unless somebody is telling something. Even with graduate students this is true. I would like to suggest that the production of practitioners calls for lots of discussion, lots of trying, attempting, fumbling, fooling around, thinking, discovering. What is more all this takes time; it cannot be rushed (p. 20).
>
> As we examined the nature of a profession, it became clear to us that the helping professions are all dependent upon instantaneous response. That is, when a child says something, the teacher has to say something back. When the client says something, the social worker has to give an answer. When the parishioner speaks to the priest, the priest has to reply, and the reply must be instantaneous. If it has to be an instantaneous response, how are you going to be sure the instantaneous response is a good one? Here we began to think in terms of a giant computer which we might use as an analogy. The giant computer takes in millions of bits of information from outside and combines this information with what is already in its memory bank. Then it gives the best answer that it can. What determines the nature of the answer which you get out? What determines the answer, of course, is dependent upon the

formula you put in in the first place, what we call the program (p. 2).

It is important for persons engaged in the training of practitioners to understand the scholar-practitioner distinction, because they call for quite different approaches to the problems of education. The training of scholars can be highly academic; the training of practitioners must be personal and experiential. What is more, it must be understood the scholars and the practitioners are likely never to understand or approve of each other. In medicine, for example, there are the practitioners, the clinicians, the doctors; but the scholars, the biologists, and people with the Ph.D.s—they look at those who are practicing medicine and say, "Oh, my God, how unscientific can you get?" (p. 21).

HUMAN COMPETENCIES IN NURSING PRACTICE

	ADN	BSN	MSN	DSN
Role Adaptation				
Reflects on own actions	✓	✓	✓	✓
Strives for objectivity	✓	✓	✓	✓
Realizes self-accountability	✓	✓	✓	✓
Maintains reality orientation	✓	✓	✓	✓
Maintains probability orientation		✓	✓	✓
Achieves insight		✓	✓	✓
Becomes self-aware				
strives for development of self-awareness		✓	✓	✓
maintains self-awareness			✓	✓
Feels secure in own self-worth			✓	✓
Uses intuition effectively			✓	✓
Maintains adaptability and flexibility			✓	✓
Develops and maintains social consciousness			✓	✓
Interactional Adaptation: Attitudinal (what the nurse feels in her own role adaptation)				
Feels warmth, concern, respect for client	✓	✓	✓	✓
Desires to give protection, support, and recognition	✓	✓	✓	✓
Trusts, believes, has faith in client's self-processes	✓	✓	✓	✓
Trusts behavior to have meaning; always goal-directed	✓	✓	✓	✓
Feels commitment and responsibility	✓	✓	✓	✓

	ADN	BSN	MSN	DSN
Interactional Adaptation: Attitudinal (cont.)				
Appreciates individual worth and uniqueness*		■	■	■
Appreciates reciprocalness in interpersonal processes		■	■	■
Empathizes with client in relation to:				
cultural identity		■	■	■
belief and value system		■	■	■
ways of perceiving and knowing		■	■	■
personality structure		■	■	■
Understands that all behavior is goal-directed			■	■
Feels unconditional positive regard for client			■	■
Maintains holistic interest in an understanding of the nature of man				■
Interactional Adaptation: Behavioral (how the nurse behaves and how it can be interpreted by others)				
Focuses on others (expresses interest, offers assistance, able to make others laugh, diverts, reinforces desired responses, shows concern and interest that may be interpreted as affability, warmth, caring, respect: introduces self, calls client by name, looks directly at client, touches, listens, responds to questions, provides information, elicits information, maintains availability)	■	■	■	■

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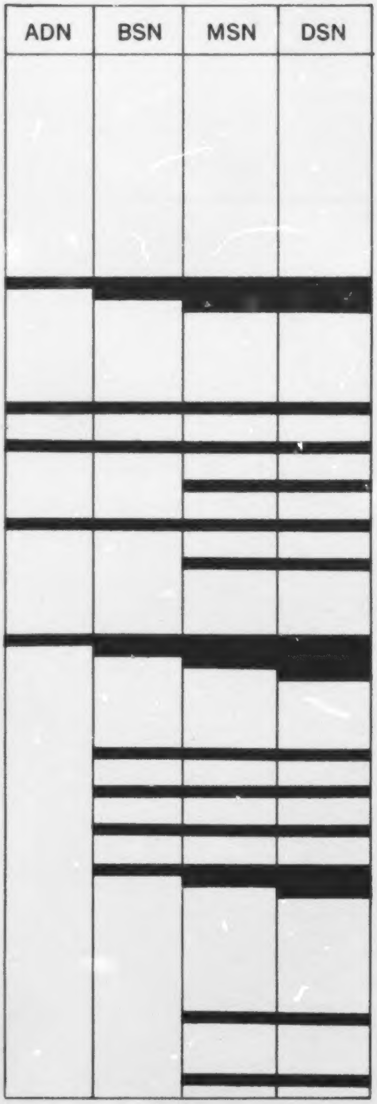
*Levels of appreciation may vary from "does not impose own values" to "respects client's life choices."



Interactional Adaptation: Behavioral (cont.)

Respects and maintains self-boundaries† (recognizes own feelings and beliefs and distinguishes them from client's feelings and beliefs; expresses own value system and personal goals; is open to experience without being threatened or overwhelmed)

Accepts negative feelings from client

dependence

aggression and hostility: overt

covert

rejection: overt

covert

Perceives, respects, and considers relationships between interpersonal systems; views individual in context of social milieu†

Perceives client as a total system

believes in potentialities

respects decisions

accepts limitations

Perceives, respects, and considers client's personal space†

Uses other's frame of reference†

Accepts client's positive regard as manifested by his positive behavior

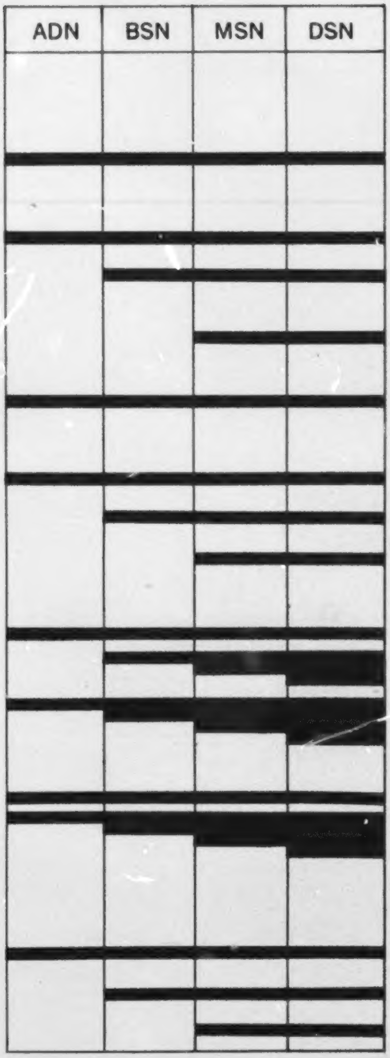
Respects and considers client's needs and their priority to him

---

†Levels of this dimension vary.

Interactional Adaptation: Synthesis (accommodation of attitudinal and behavioral interactional adaptation)

- Protects and supports
- Accepts others noncritically
  - accepts limitations
  - recognizes potentialities
  - feels unconditional positive regard
- Nurtures by strengthening, comforting, consoling, and sharing
- Develops rapport
  - listens
  - promotes growth
  - fosters self-realization
- Evokes data of an emotional nature
  - listens
  - deliberately and verbally†
- Interprets data and makes appropriate for client†
- Deals appropriately with normal responses (overt/covert)
- Helps client deal with stress†
- Helps client deal with dissonance
  - deals with client's conflicts
    - recognizes
    - manages
    - resolves



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†Levels of this dimension vary.

	ADN	BSN	MSN	DSN
Interactional Adaptation: Synthesis (cont.)				
Helps client deal with dissonance (cont.)				
reconciles conflicting needs		▬	■	█
intervenes in crisis			▬	█
suggests alternatives:				
recognizes		▬	▬	▬
creates			▬	▬
Deals with abnormal responses				
overt		▬	▬	▬
covert			▬	▬
Helps groups to deal with stress				
usual			▬	▬
abnormal				▬
Assists clients to achieve growth and understanding				
listens		▬	▬	▬
analyzes			▬	▬
promotes self-realization				▬
Guides, directs, activates and structures events and situations		▬	■	█
Motivates, acts as a catalyst, moves clients toward a solution		▬	■	█
Facilitates		▬	▬	▬
Sets limits		▬	▬	▬
Compromises		▬	▬	▬
Teaches clients		▬	▬	▬
Demonstrates		▬	▬	▬

	ADN	BSN	MSN	DSN
Interactional Adaptation: Synthesis (cont.)				
Structures interpersonal interactions according to client's:				
belief system			▬	▬
value system			▬	▬
personality structure			▬	▬
Knows timing			▬	▬
Coordinates			▬	▬
Collaborates			▬	▬
Manipulates			▬	▬
Consults			▬	▬
Models			▬	▬

FUNCTIONAL COMPETENCIES

Functional competencies, when separated from intellectual or affective abilities, are easily taught and learned but they are never used exclusively.

Functional competencies were defined by the project members as the learned ability to perform competently those activities that:

—are basically psychomotor or manipulative;
—insure physical comfort and safety for the client;
—implement diagnostic, preventive, and treatment modalities and protocols.

Functional competencies may be broadly classified into measures for:

—comfort, hygiene, and safety;
—nutrition, fluids, excretion, and secretion;
—diagnosis and treatment.

But technical tasks and competencies change as do health care problems confronted by a particular culture. In our own society within the next twenty to forty years there will be shifts in the population's mean age, an increase in sociocultural diseases, a shift from care highly oriented to illness to delivery strategies aimed at preventing disease and promoting health. As the focus changes in these areas, the public mandate to nurses will change, necessitating the acquisition of new technical skills by the nurse as her old ones obsolesce and disappear.

Moreover, technologies will expand and improve in acute illness care causing the specific tasks in nursing services to change. New discoveries and more scientific knowledge will modify the nurse's activities. Nurses will be required to acquire new functional abilities on a continuing basis. There are predicted changes in the population ratios, in new kinds of health tasks, in communication technology, in health care delivery patterns, and in the balance of power between providers and the public. New functional abilities will be mandated for nurses by these changes. The blurring of roles for health care providers will also oblige nurses to acquire new skills.

The task group working on the taxonomy of functional competencies made the following assumptions:

1. The greater the understanding of biophysical processes possessed by the nurse, then the more is her ability to deal effectively with complex variables in nursing events and situations of a highly technical nature. Complexity varies with the need for maintaining or manipulating various system levels (i.e., cells, organs, systems, organisms) or the interrelationships within and between them.

2. The setting for practice also influences the decision about which nurse should be practicing there. The more structured or controlled the setting in which nursing events or situations occur, then the more back-up support and direct supervision should be available. Functional tasks may be delegated to workers with less cognitive and human skills when expert help is readily available. Or to phrase this notion in a slightly different manner, the greater the understanding of biophysical processes possessed by the nurse, the greater the number of less knowledgeable assistants for whom she may accept responsibility. Selected technical tasks may be performed safely by those who lack a broad understanding of physiological processes if adequate and immediate supervision is available.

3. The greater the degree of acute physiological illness, then the more technical tasks there are to be performed usually. The more severe the degree of illness, the greater the need for direct care to be given by nurses with more understanding of biophysiological reactions.

4. The more complex the nursing situation is, then the more highly developed and interrelated the skills required including functional, conceptual, and human ones.

5. Students learn functional skills by practicing them. And there is no substitute for practicing these skills in the "human" laboratory,

on the clinical units, in the medical and nursing clinics. Functional skills obsolesce if not practiced consistently.

Graphically the assumptions are shown in Figure 7.

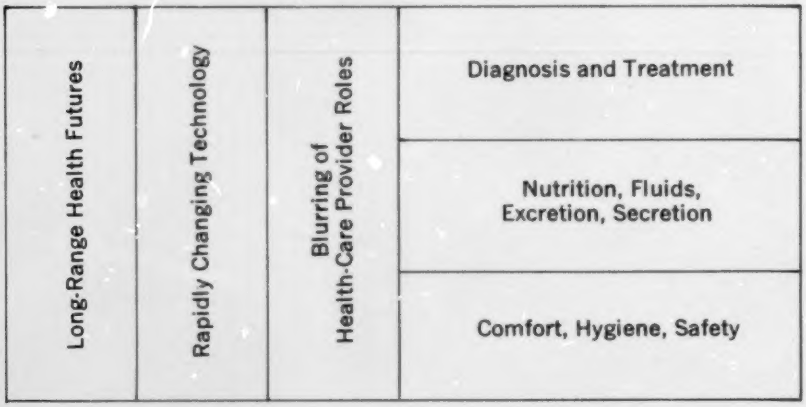
Long-Range Health Futures
Rapidly Changing Technology
Blurring of Health-Care Provider Roles
Diagnosis and Treatment
Nutrition, Fluids, Excretion, Secretion
Comfort, Hygiene, Safety

Figure 7

Functional Skills Paradigm

FUNCTIONAL COMPETENCIES IN NURSING PRACTICE

	ADN	BSN	MSN	DSN
Comfort				
Positioning				
Ambulating				
Manipulation and control of immediate environment: e.g., noise, temperature, humidity, sensory input, bed linens, accessories				
Hygiene				
Maintain and restore integrity of skin, mucous membrane and appendages				
Basic care of intact skin and simple prostheses (eyeglasses and dentures)				
Advanced care of decubiti, ostomies, and braces				
Safety				
Protection against infection				
aseptic techniques including isolation procedures				
basic environmental hygiene				
proper use, care, and disinfection of equipment				
Protection against environment				
insure safety of basic equipment prior to and during use: e.g., wheel locks, Stryker frames, wheel chairs, hot water bottles				
insure safety of advanced equipment prior to and during use: e.g., electrical equipment, specialty equipment				

	ADN	BSN	MSN	DSN
Safety (cont.)				
Protection against self and others				
use of restraints, both physical and environmental, including bed rails, drug security and other necessary measures				
Nutrition and Fluid				
Preparation for nutritional and fluid intake				
Establish, administer, and monitor route				
per OS				
per tube				
parenterally				
Excretion and Secretion				
Measure and estimate fluid losses				
Describe attributes of fluid, excretory, and secretory losses				
Provide for secretion-excretion removal				
basic—oral, pharyngeal, suction, enemas				
advanced—clapping and percussive respiratory techniques				
tracheal suctioning				
catheterization				
gastric aspiration				
Establish and maintain drainage systems				
simple: e.g., humidifiers, nebulizers, Isolettes				
complex: e.g., M.A.I., Bourne, Emerson				

	ADN	BSN	MSN	DSN
Recording of Data				
Record performance of procedures	—	—	—	—
Verbalize and record client data	—	—	—	—
Complete designated forms, report writing	—	—	—	—
Monitor and record supplies and operate equipment	—	—	—	—
Computer programming				—
Diagnosis				
Positioning	—	—	—	—
Secure and process specimens	—	—	—	—
basic: urine specimens, including catheterization; urine tests—sugar, acetone; nebulized sputum	—	—	—	—
intermediate: Pap smear, venipuncture, basic blood tests, hematocrit	—	—	—	—
advanced: dialysis, pulmonary function tests, specialty tests	—	—	—	—
Conduct screening and diagnostic tests				
Denver developmental	—	—	—	—
EKG	—	—	—	—
skin test	—	—	—	—
Elicit historical data (data base for nursing diagnosis)	—	—	—	—
Perform physical exam				
basic: vital signs, "basic" observations (cyanosis, consciousness), B/P	—	—	—	—
intermediate: palpation, percussion, auscultation, F.H.T.	—	—	—	—
advanced: vaginals, pelvics, rectals		—	—	—

	ADN	BSN	MSN	DSN
Diagnosis (cont.)				
Prepare and administer medications				
per OS				
IV—including blood and blood by-products; blood adm.—state law				
all other routes—topical, sub q., conjunctival				
Establish and maintain monitoring system				
Treatment—All Skills Included under Diagnosis, plus:				
Dressing and wound care				
basic: "Band-Aid"				
advanced: burn dressing				
Application of support devices and braces				
basic: elastic stockings				
advanced: splinting, traction				
Maintain total systems				
basic: Foley care				
advanced: insure patency of chest tubes				
Perform physical therapy				
active and passive exercises				
range of motion				
basic: use of "simple" equipment				
advanced: use of advanced equipment				
Perform minor surgery				
debridement, incision and drainage, removal of foreign bodies from orifices				

	ADN	BSN	MSN	DSN
Treatment (cont.)				
Perform minor surgery (cont.)				
perform resuscitative measures				
basic: artificial respiration, external cardiac massage	▬	▬	▬	▬
advanced: emergency tracheostomy, defibrillation			▬	▬
deliver babies			▬	▬
post-mortem	▬	▬	▬	▬
occupational and recreational therapy	▬	▬	▬	▬
religious sacraments	▬	▬	▬	▬

CHAPTER 5

An Overview of the Theoretical Framework

The purpose of this section is to summarize the assumptions upon which the work of the project is based. Each assumption is listed in its simplest form and offered for its heuristic value to the curriculum developer. In the preceding volume, *A Workbook on the Environments of Nursing*, these assumptions were explained in detail.

SYSTEMS THEORY

The first assumption is the notion of "systems" and "systems theory." This notion is at the core of the project's products, schemas, taxonomies, recommendations. Systems theory was selected because it was the best means of passage from the present to the future: All other assumptions follow from this one.

HEALTH CARE

Health care may be defined as an interdependent system composed of a set of service components and, as such, is as susceptible to change caused by social issues and advances as are other systems in society, such as education, government, organized religion, or an even more abstract system such as science.

The weight of opinion about the place of health care in society has changed to the belief that health care is every person's right, and the public is demanding, through social and governmental processes, equitable health care for all citizens. As a consequence Congress is concerning itself with a governmental plan for the national distribution of health services and national health financing will be forthcoming within the next decade. When this event happens, the health care system will compete with other social interests for its share of the tax dollar; one-half of health care costs are likely to be funded nationally.

The balance of power concerning health policy determination is changing. More than ever before in our history, the control of health policy and funding will be less exclusively in the hands of health care professionals. A change in the mixture of public and private health care delivery systems, resulting from national health financing, will necessitate more attention being given to regulating the interrelationship between the two. National and/or regional health policy boards will be established.

The public sector of health care is likely to be reorganized by one of several different structures: (1) categories of care (primary, secondary, tertiary); (2) health maintenance organizations with tie-in to secondary and tertiary centers; or (3) a regionalization-of-services plan. Health maintenance and disease prevention models will include the use of sophisticated technology and especially multiphasic screening that assists in differentiating the healthy client, the early sick client, and the ill client.

The role of the hospital will change when disease prevention and health promotion become a reality. Secondary care centers will continue to provide services for routine surgeries, deliveries, and treatment of diseases presenting acute episodes. Emergency services with backup—via telephone, television, and helicopter services—from tertiary centers will expand. Tertiary care centers will provide services for complex surgeries, treatment of complicated and rare illnesses in acute episodes, research, teaching, and monitoring of primary and secondary care. The whole process of care and cure in hospitals will be more intense and complex.

Health care in this country is currently in the first stages of a significant shift in attention from illness care and cure toward preventive care and the maintenance of health. We cannot expect the physician to be the inevitable first contact for clients entering the health care system, because there are too few general practitioners, pediatricians, and internists. There also exists an underutilization of some health care providers, and a maldistribution of others.

Many of the major causitive factors of disease in this country are now thought to be socioculturally determined; however, medical care continues to be focused on the traditional biophysical areas. The biomedical technology used for the treatment of acute illnesses has attained great power, but the controls over its use have been essentially laissez-faire, and the free enterprise system of health services so ineffectual that medical care may now be in a stage similar to that at the end of World War I when the probability of a patient's benefiting from treatment was as low as 50 percent or less. Quite apart from the issue of safety, the efficacy of high technology services is more and more questionable in the light of the increasing median age of the population and the shift from acute to chronic patterns of disease (Battistella, 1976).

Nursing is one of the major sectors of the health care system: Seen from the point of view of systems theory, nursing is a critical subsystem, a part of an interdisciplinary effort to promote and maintain health, prevent disease and disability, to care for, cure, and rehabilitate the sick. Nursing shares with other disciplines the responsibility to provide services that foster the highest potential level of wellness for every individual, family, and community.

As a result of the predicted changes in health care services, however, the roles for some nurses will be expanded and changed. When the larger system of primary care services becomes a reality, the knowledge base of each health care occupation will become increasingly shared with other health care disciplines.

Roles for nurses are emerging in disease prevention, health maintenance, long-term management of chronic illness, gerontology, the management of stress, community planning, and health education. And these new roles exist in the largest area of unmet health needs, in primary care, and nurses are capable of making a major contribution in this arena.

Moreover, national health care financing will result in a new public mandate to nurses: to provide a larger share of direct primary services. In the public sector, the nurse is likely to become the gate-keeper to the entire system of health care. She will: (1) assess the health-illness status of clients seeking entry to the system; (2) treat clients presenting minor pathological conditions; (3) screen and refer clients needing assistance beyond her competence to treat; (4) manage the long-term care of clients with chronic health problems; and (5) teach the basic health promotion concepts.

Nurses will continue to fulfill the traditional role in hospital and community settings. Traditional roles in nursing are not likely to change with the passage of time, or change in geographic setting, or new developments in medical diagnosis and treatment. Certain activities for the nurse in these roles will change, certain methods of practice will change, but the central purpose of the traditional role will not change. Particularly the role of the nurse in secondary care settings is not likely to change in purpose or function.

Two expanded roles for nurses are emerging in acute care settings. One is that of the nurse specialist practicing in the intensive care areas of medical centers or research hospitals; it includes coronary care, intensive newborn care, burn care, post-operative care for experimental and complex surgery, emergency and other trauma, and medical care for the critically ill. The other role is that of the nurse clinician, "the generalist who is a specialist," who is theoretician, practitioner, researcher, consultant, and staff teacher to other nurses both as individuals and as groups. The role of nurse clinician was designed to be analogous to the medical clinician so that a role complement—an alter to the physician—would exist in acute care settings.

A role structure with like meaning for the practitioner and employer should be as follows:

A. The beginning level of nursing practice is peopled with vocational nurses who are nurse-providers that serve as assistants to other nurses licensed to practice "professional" nursing*.

B. The first level of professional nursing practice is peopled with nurses who are supervised staff workers caring for clients who are experiencing acute or chronic illnesses that are common and well-defined. These clients have been identified by other more highly knowledgeable health care providers as being ill, in need of diagnostic evaluation, or routine health-illness monitoring. This nurse provider continues the practice of the traditional nursing role and is involved with nursing processes that are standardized, in common use, and directed toward alleviating both biophysical and psychosocial problems.

C. The second level of professional nursing practice is peopled with nurses who have a greater depth of knowledge about nursing processes in both acute and primary care settings. In acute care settings the nurse's practice is focused on clients experiencing acute illness episodes and presenting problems that are uncommon and complex. In primary care settings the practice of the nurse is directed toward maintaining and promoting the client's health and alleviating minor pathological conditions. The presenting or continuing problems of the client may need the immediate attention of the nurse or she may need to modify her nursing processes to adapt to an unexpected event presented by the client. In acute care units, the nurse cares for clients whose health-illness problems are common and recurring or convalescent, gives leadership to other less knowledgeable workers, and serves them as teacher and consultant.

D. The third level of professional nursing practice is peopled with nurses who care for clients presenting multivariant problems that are complex and interrelated. This nurse possesses expert clinical judgment and technical competence in direct client care. She is not only a role model of expertness but an experiential teacher and consultant to other nurses and other types of health care providers. She assesses both presenting and continuing problems, infers a solution, and implements her plan of care whether it is preventive, palliative, supportive, or therapeutic. This nurse studies a clinical situation until she has identified the essence of the nursing problem and then searches for a solution in whichever bodies of knowledge are applicable. She has a broad base of intellectual competencies and a matrix of theory that can be used in determining problems meriting investigation as clinical nursing re-

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*In this context *professional nursing* has traditionally meant the *registered nurse*.

search. By working with the most complex problems in nursing, this nurse studies the nature of such problems and provides a literature—clinical papers, clinical research—that helps to revise the general practice of nursing. This nurse may have either generalist or specialist skills and abilities. She functions as an independent practitioner and an interdependent member of the health team. This nurse functions in all settings where health-illness care is given but may be known as a "nurse practitioner" in primary care settings and as a "clinical specialist" in acute care settings.

E. The fourth level of clinical practice is peopled by nurses whose practice is directed into sub-specialization in an area of clinical interest. The scope of practice narrows but the depth of understanding increases. The practice is directed toward clients who present highly complex problems that are limited to the practitioner's specialty.

HIGHER EDUCATION

Nursing education is a part of an interdependent system of higher education that is changing more rapidly than ever before in its history. "It is no longer true that it takes thirty or fifty years for a new idea to be incorporated into the mainstream of education" (Smith, 1974, p. 37). In fact, diversity has become the *idée fixe* of the decade.

There is a new student in higher education—the older, the employed, the less academically talented—who is demanding that education be made available at more times and in more places. There is a corresponding decrease in the homogeneity of the student body. There is a decreasing amount of common abilities and aptitudes, common goals and purposes, overall ways of learning and knowing. There are growing differences in life-styles.

This new student is also demanding credit by examination, advanced placement, and course extension. "The domain of credit by examination lies between the closed state of the classroom and the open field of experiential learning. . . . Long in the backwater of higher educational concern, credit by examination and its companion practice, advanced placement, can no longer be given low priority by college faculty and administrative officials. There is an increasing societal awareness of the value of credit by examination on the part of students, parents, secondary teachers, officials of state college systems, and legislators. This heightened off-campus consciousness requires action or reaction on the campus" (Haag, 1975, p. 1).

New ways of teaching and learning, fitting higher education into many life-styles, meeting more diverse educational needs, will require new methodologies in education. "Developmental education" or learning by diagnosis and prescription is definitely in the short-range future of many students and institutions. Diagnosis will include: present abilities, special aptitudes, cognitive styles, learning strategies most suited. Prescriptions will include: plans of instruction, methodologies, teachers, field placements.

Growing out of our concern for recurrent and continuing education is a dynamic concept of life-long learning. Because of our current preoccupation with self-fulfillment and expansion of consciousness, people will be constantly dipping in and out of the system for rejuvenation, seeking the "good life." Alumni institutes and vacations on campus are activities that exemplify the heightened interest in life-long learning. With the growing complexity of the modern world, continued learning may be necessary.

The delivery of educational services is changing. The geography and scheduling of education traditionally have been designed to meet the demands of a student population that was young enough, unencumbered enough, and wealthy enough to gather together in rather isolated locations—the pastoral setting—to devote long periods of time exclusively to the acquisition of knowledge and skills. Such arrangements no longer meet the needs for many students and are therefore uneconomic for many schools. Urban schools, community colleges, satellite annexes and branches of major institutions, these and similar arrangements are changing the geography of education. "Feeder systems" similar to those described for health care are developing in education. Junior colleges and vocational and technical institutions are feeding students into upper-division universities and colleges either with a mission solely devoted to that purpose or as a part of planned student articulation between institutions.

The proportionate sizes (in terms of enrollment) of the parts of the system of higher education will surely change in the coming decade. The technical-vocational sector is showing phenomenal growth. At the bachelor's degree level, although enrollments are still increasing, the rate of growth has slowed down. Graduate schools are showing a slight growth currently, and many professional schools are finding it necessary to limit enrollments.

Institutional services, curriculum requirements, and methods of teaching and learning will continue to become more diversified, tending toward increased flexibility and autonomy for the learner. Education will be available at more times and places: by television to out-reach areas, by telephone, by videotape, by traveling scholar. Self-paced learning will be available in more diverse content areas and will use such strategies as computer-assisted instruction, autotutorial teaching, modules and mini-courses, contract learning, mastery learning.

Education will become more systematized: State-wide planning groups will gain more influence and interinstitutional cooperation and collaboration will become more common, as will consortia, articulation and other cooperative endeavors.

The culture appears to be moving in the direction of a "learning society" encompassing reciprocal learning-teaching arrangements. Recurrent education will be built into the system.

Professional education will continue to increase in importance. The body of knowledge will change to include: increased information concerning socio-cultural processes and techniques for working with people, more qualitative methods and research, a changing meaning of professionalism. Professional programs are also likely to be shortened and evaluation by competency-based clinical requirements may become frequent.

Postscript: Beyond Theory

The assumptions upon which the seminar agreed about health care and higher education point clearly to changes in traditional ways of doing things. Once the assumptions were in place, nursing roles could be distinctly envisaged and educational implications derived.

Having developed a viable role structure for nursing and projected appropriate educational patterns, it remained for the seminar to frame the ten broad recommendations which follow, and to disseminate the findings and recommendations as widely as possible.

Dissemination, however, is not enough. All those associated with the Nursing Curriculum project feel strongly that, while the findings and recommendations speak to the important issues, the curricular innovations involved need trial and testing. Changes in the mechanisms for health care delivery are demanding that more attention be given to educating nurses for roles that are expanding and diversifying. The profession is particularly lacking in personnel prepared to function in primary health care settings; ways must be found to expedite the institutionalization of this role into nursing curricula. At a time when more is being expected in knowledge and services, nursing is deficient in persons prepared to provide leadership —administrators, clinical specialists, nurse practitioners, nurse researchers. Other problems and questions are also acute: articulation between programs, the sharing of resources, interdisciplinary efforts and collaboration, clinical competencies for nursing faculty, continuing education, the need for flexible, open curricular designs and teaching strategies.

Demonstration and implementation of the project's ideas will enable nursing to assess the potential of the proposals put forth in this volume. The Nursing Curriculum project believes that its findings and recommendations hold much promise for magnifying nursing's contribution to the health care of people.

FINAL RECOMMENDATIONS*

1. The practice of nursing at all levels is based on a body of knowledge that has at its center a set of competencies that are universally recognized as necessary to the provision of secondary care. This base of nursing, this set of competencies, should be further defined and developed.

2. The knowledge that is fundamental to each more advanced level of nursing practice is based on sets of competencies, each of which is characteristic of its own level and builds on the base of secondary care. The body

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***See volume 5 of this series for an account of the process by which recommendations were developed and the rationale underlying each.**

of knowledge expands at each more advanced level of nursing practice and includes the different sets of common competencies necessary to the provision of primary, secondary, and tertiary care. The body of knowledge, these sets of competencies, should be further defined and developed.

3. A system of nursing education should be designed and developed to prepare graduates for different levels and types of nursing practice, a system that reflects the structure of nursing knowledge as described in recommendations 1 and 2.

4. The associate degree curriculum should be focused on the preparation of graduates to give secondary care.

5. The baccalaureate curriculum should be focused on the preparation of graduates to give not only secondary care at the beginning level, but also primary care at the beginning level and—at the student's choice—either primary care at an advanced level, secondary care at an advanced level, or tertiary care at a beginning level.

6. The graduate curriculum should be focused on the preparation of leaders to strengthen nursing's contribution to health care; therefore, graduate nursing education should be the first priority of nursing education for at least the next decade. To this end, graduate programs should be prepared to strengthen quality, expand curricular offerings, and increase enrollments.

7. Programs of higher education should incorporate continuing education as part of their regular structure, according it equitable priority in allocation of time, attention, and resources, and assigning to it faculty with academic credentials equal to faculty of other programs.

8. Programs of nursing education at all levels must incorporate flexibility in offerings, requirements, and time-and-place options for study.

9. Programs of nursing education should seek and sustain interinstitutional cooperation in order to strengthen educational services and resources.

10. Curricular structure in nursing should be interdisciplinary as well as intradisciplinary. Cooperation and collaboration with other health care disciplines should be sought actively by nurse educators. Where appropriate, joint courses at several levels should be developed and nursing faculty should be given joint appointments in other departments.

APPENDIXES

Appendix A

Core of Nursing Knowledge

ENTRY LEVEL: CHARACTERISTICS OF PRACTICE IN SECONDARY CARE

Practice:

- —is directed toward clients who are experiencing acute or chronic illnesses that are common and well-defined and who have been identified as being ill or in need of diagnostic evaluation.
- —consists of processes that are standardized, in common use, and directed toward alleviating both biophysical and psychosocial health problems, the outcomes of which are usually predictable.
- —includes making nursing judgments on scientific knowledge that is specific and factual.
- —is concerned with individuals but is given within the context of the family and the community.
- —is under the leadership of a more experienced staff worker, a generalist clinician, or a clinical specialist.

ENTRY LEVEL COMPETENCIES: GENERALIST CLINICIAN

In addition to secondary care competence at the beginning level, the generalist clinician possesses beginning competencies in primary care (described below), plus other competencies in an area of concentrated study.

Primary Care: Level I

Practice:

- —is directed toward providing services for health maintenance and health promotion—
  - —toward interpreting health for individuals and groups within the context of their sociocultural milieu,
  - —toward developing goals with clients that are related to the normal stresses of daily living,
  - —toward treating or monitoring clients having selected minor pathological conditions.

—consists of processes that enable the nurse to—

- —assess the health of normal individuals or clients with minor pathology,
- —screen and either treat or refer clients who are in need of further treatment or attention,
- —manage the long-term care of clients with chronic health problems,
- —teach the basic health promotion concepts.

—includes making independent decisions about health maintenance.

—is concerned with individuals and groups within the context of their sociocultural milieu.

—is concerned with establishing a data base that is interpreted clinically.

—is based on knowledge that is developing and evolving; is future-oriented; contains a moderate level of abstraction; involves critical thinking.

—includes the application of clinical research to decision-making.

—occurs in a setting having consultive and referral services readily available.

Secondary or Tertiary Care: Level II*

Practice:

—is directed toward clients experiencing acute illness episodes and presenting problems that are uncommon, moderately complex, and usually immediate.

—is directed toward clients who have been identified as being acutely or critically ill.

—consists of the use and development of innovative and less standardized processes that are geared and adapted to the specific needs of clients; outcomes are less predictable and require additional monitoring and a broader knowledge base from which to draw inferences.

Primary Care: Level II*

Practice:

—is directed toward clients from more diversified populations requiring health maintenance and health promotion services.

—consists of processes that—

  —set the appropriate priorities in meeting needs of population being served,

  —coordinate the total services needed by individuals and groups,

  —use the appropriate consultation and supervision,

  —include independent primary assessment, such as history, physical, emotional and developmental diagnostic work-up.

—consists of developing innovative and less standardized processes geared and adapted to meet the needs of individuals, groups, and communities where outcomes are less predictable and require additional monitoring over a longer period of time.

—includes knowing the nature of the community, the services available, and the means of access to those services.

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*Alternative areas of concentration.

Special Interest Areas: Common Competencies

Practice:

—is based on a broad range of principles and concepts drawn from a variety of basic and applied natural and behavioral sciences.

—includes making nursing judgments based on the analysis of numerous variables and the prediction of future clinical events.

—includes the application of clinical research to decision-making.

—is based on clinical decisions made from the integration of knowledge of biophysical and psychosocial cues with the recognition of their implications.

—is directed toward providing leadership in the management of care for groups of clients as well as those personnel assigned to provide that care.

—is directed toward developing collaborative relationships with other health workers providing other kinds of care and services to clients.

—is more self-directive, but the nurse recognizes the need to seek additional information and consultation from peers or higher-level practitioners.

ENTRY LEVEL COMPETENCIES: SPECIALIST CLINICIAN

The practice of the specialist clinician is directed toward the care of clients presenting multivariant problems that are complex and involve multiple system analysis. This nurse will be a comprehensive generalist to some and a specialist to others, a model of expertness, a staff consultant and educator, a role model, an experiential teacher, a primary therapist, a consultant, a clinical researcher, and a provider of clinical literature. She works with the most complex problems in nursing, possesses advanced clinical knowledge, improves her own practice, gives and demonstrates care, and plans and supervises staff education. She assists in establishing standards of care.

Practice:

—is directed toward the care of clients presenting complex problems involving multiple system analysis and solutions.

—is specialized in a particular clinical category (based on either the medical or nursing model) and independent nursing services may be provided in that specialty.

—consists of processes—

  —that are focused on analyzing the interaction between models, concepts, theories and the clinical data base,

  —that reflect refined clinical abilities needed to: (*a*) give and demonstrate care, (*b*) design and plan nursing care, (*c*) intervene by preventive, palliative, supportive, and therapeutic measures, (*d*) modify and adjust plan.

—includes making nursing judgments based on a synthesis of concepts, principles, models, and theories to solve complex problems; and making independent decisions to analyze presenting and continuing biophysical and psychosocial cues and weight them in relation to probable remedies and palliative measures.

—is interdependent but largely self-directed.

—includes utilization of clinical research and collaboration in the research process.

PROJECTED ROLE EXPECTATIONS FOR THE CLINICAL SPECIALIST

Practice:

—is directed toward advancing nursing knowledge and theoretical understanding by—

  —using a theoretical matrix to formulate concepts for clinical work and research;

  —contributing to the body of nursing knowledge through research and practice by—

    —identifying problem areas for study and investigation; possessing well-developed problem-solving abilities and a mastery of methods to analyze problems,

    —making judgments, based on a synthesis of concepts, principles, models, theories, to solve complex problems,

    —developing innovations in practice based on emerging new knowledge,

    —evaluating outcomes of nursing intervention,

- —keeping current with the nursing and health care literature.

- —is focused on using intellectual, technical, and human competencies that are expert by—
  - —possessing first-hand knowledge of the pathology dealt with;
  - —being a nurse therapist and expert practitioner;
  - —possessing refined clinical skills and assisting others to develop high-level performances by—
    - —giving and demonstrating care,
    - —teaching,
    - —designing, diagnosing needs, and planning nursing care,
    - —modifying and adjusting that plan,
    - —intervening in the client's health-illness process using preventive, palliative, supportive, and therapeutic measures.
- —is interdependent but largely self-directed; practitioner is—
  - —consultant,
  - —role model to other nurses,
  - —role alter to physician in hospitals,
  - —patient advocate in hospital setting and follows client to home and return to clinic.
- —is directed toward expecting change, seeking out change, innovating and initiating change, and possessing freedom to explore own functions.
- —is often directed toward coordinating the total health care plan for the client.

PROJECTED ROLE EXPECTATIONS FOR THE NURSE PRACTITIONER

Practice consists of:

- —assessing the health-illness status of clients by—
  - —securing and recording a complete health history and critically evaluating findings;

- —assessing individual and family health needs.
- —performing a complete physical examination using the techniques of observation, inspection, auscultation, palpation, percussion, and communication.
- —developing a differential diagnosis by discriminating between normal and abnormal findings in health history and physical assessment.
- —performing selected diagnostic tests and procedures.
- —reaching a specific diagnosis and deciding which clients can be served by the nurse and which clients are to be referred to others.
- —prescribing a plan of care.
- —monitoring client's health under plan prescribed:
    - —common medical problems,
    - —stable phases of chronic illness,
    - —uncomplicated ante and post partum care,
    - —care of minor accidents to include suturing.
- —counseling and teaching client and family.
- —acting independently in meeting health needs through anticipatory guidance and relevant health teaching.
- —recognizing forces and resources in a given community that assist or inhibit individuals and families in coping with their ongoing health-illness problems.
- —identifying social and psychological factors inherent in health-illness situations.
- —coordinating health management.

Appendix B

Expanded Role Programs in Nursing in the Southern Region

STATE/INSTITUTION	PROGRAM	LENGTH	CERT./ DEGREE	DIRECTOR
Alabama				
University of Alabama in Birmingham	Pediatric Nurse Practitioner	2 q. 18 wks.	C	Ms. Isobel H. Thorp Associate Professor School of Nursing
Arkansas				
University of Arkansas	Training Program for Nurse Practitioners	9 mos.	C	Dr. Elois R. Field, Dean School of Nursing
Florida				
University of Florida	Nurse Practitioner for Adult Care	6 mos.	C	Dr. Amanda S. Baker, Coordinator, Continuing Education College of Nursing
University of Miami	Family Nurse Practitioner	10 mos.	C	Mrs. Louisa M. Murray Associate Professor School of Nursing
Georgia				
Emory University	Nurse Practitioner in Adult Health	5 mos.	C	Ms. Mary Hall Associate Professor School of Nursing
Kentucky				
University of Kentucky	Nurse-Midwifery	12 mos.	M	Ms. Elizabeth Bear Coordinator College of Nursing

STATE/INSTITUTION	PROGRAM	LENGTH	CERT./ DEGREE	DIRECTOR
Louisiana				
Northwestern State University	Medical-Surgical	12 mos.	M	Dr. Marie DiVicenti, Head Masters Program College of Nursing
Tulane University	Family Nurse Program Family Nurse Program	6 mos. 2 sem. + SS	C MPH	Mrs. Edna Treuting, Director Nursing Programs School of Public Health
Maryland				
University of Maryland	Pediatric Nurse Practitioner	4 mos. + 8 mos.	C	Ms. Frances P. Koonz Director, Continuing Education School of Nursing
University of Maryland	Primary Care Practitioner	4 mos. + 12 mos.	C	Mrs. Rachel Z. Booth Assistant Professor School of Nursing
Mississippi				
Mississippi University for Women	Family Nurse Clinician	3 sem. + SS	M	Dean, School of Nursing
University of Mississippi	Family Health Nurse Associate	12 mos.	C	Ms. Linda Pearce School of Nursing
North Carolina				
Duke University	Family Health Nurse, Family Nurse Therapist	3 sem.	M	Dr. Ruby L. Wilson, Dean School of Nursing
East Carolina University	Pediatric Nurse Practitioner	4 mos.	C	Dr. Mallie Penry School of Nursing
East Carolina University	Family Nurse Practitioner	12 mos.	M	Dr. Mallie Penry School of Nursing

STATE/INSTITUTION	PROGRAM	LENGTH	CERT./ DEGREE	DIRECTOR
North Carolina (cont.)				
Lenoir-Rhyne College	Maternity/Child Health	16 wks.	C	Dr. Frances Farthing Chairman, Nursing Dept.
UNC—Chapel Hill	Cardiovascular Clinical Nurse	6 mos.	C	Ms. Laurice Ferris School of Nursing
UNC—Chapel Hill	Family Nurse Practitioner	12 mos.	C	Ms. Julia Watkins School of Nursing
UNC—Chapel Hill	Nurse Midwifery	6 mos.	C	Ms. Sandra Regenie School of Nursing
UNC—Greensboro	Child Health	16 wks.	C	Mrs. Marilyn Evans Instructor School of Nursing
UNC—Greensboro	Youth Health	16 wks.	C	Mrs. Rebecca Taylor Assistant Professor School of Nursing
UNC—Greensboro	Maternal, Gynecological & Family Planning	16 wks.	C	Mrs. Margaret Klemer Associate Professor School of Nursing
UNC—Charlotte	Nurse Practitioner	2 sem. + 10 wks.	M	Mrs. Vera Smith Director, Continuing Education in Nursing
South Carolina				
Medical University of South Carolina	Nurse Midwifery	12 mos.	C,M	Ms. Carmela Cavero College of Nursing
University of South Carolina	Family Nurse Practitioner	10 mos.	C	Ms. Adelaide Kloepper Professor, College of Nursing

STATE/INSTITUTION	PROGRAM	LENGTH	CERT./ DEGREE	DIRECTOR
Tennessee				
University of Tennessee–Memphis	Adult Health Nurse Practitioner	28 wks.	C	Ms. Pat Brisley College of Nursing
University of Tennessee–Memphis	Physical Illness Nurse	50 wks.	M	Dr. Mary Morris College of Nursing
University of Tennessee–Memphis	Community Mental Health Nurse	50 wks.	M	Dr. Shirley Burd College of Nursing
University of Tennessee–Memphis	Community Family Health Nurse	50 wks.	M	Dr. Beverly Bowns College of Nursing
University of Tennessee–Memphis	Pediatric Nurse Associate	20 wks.	C	Ms. Brenda Mills College of Nursing
Vanderbilt University	Family Nurse Clinician	12 mos.	M	Dean Nel Getchel School of Nursing
Vanderbilt University	Primex C.E. Program	12 mos.	C	Ms. Virginia George School of Nursing
Texas				
Texas Woman's University	Pediatric Nurse Practitioner	11 wks.	C	Ms. Mary E. Cates, Director Continuing Education College of Nursing
Texas Woman's University	Geriatric Nurse Practitioner	11 wks.	C	Ms. Mary E. Cates, Director Continuing Education College of Nursing
Texas Woman's University	Family Nurse Clinician	12 mos.	M	Ms. Edith Wright College of Nursing

STATE/INSTITUTION	PROGRAM	LENGTH	CERT./ DEGREE	DIRECTOR
Texas (cont.)				
University of Texas	Family Nurse Practitioner	12 mos.	C	Ms. Ruth Stewart School of Nursing at San Antonio
University of Texas	Pediatric Nurse Practitioner	4 mos.	C	Ms. Chloe Floyd School of Nursing (Galveston)
Virginia				
University of Virginia	Pediatric Nurse Practitioner	4 mos.	C	Dr. Barbara Brodie School of Nursing
University of Virginia	Emergency Nurse Specialist	4 mos.	C	Ms. Denise Geolet School of Nursing
University of Virginia	Family Nurse Practitioner	12 mos.	C	Ms. Susan Lynch Medical Center
Virginia Commonwealth University	Family Nurse Practitioner	1 yr./ 2 yrs.	C M	Ms. Marjorie Keller Dr. Martha Borlick School of Nursing, MCV
Virginia Commonwealth University	OB-GYN Nurse Practitioner	6 mos.	C	Dr. Margaret Spaulding Chairman, M-C Nursing School of Nursing, MCV
West Virginia				
West Virginia University	Pediatric Nurse Associate	10 mos.	C	(Phasing out)

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